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HEALTH MAINTENANCE ORGANIZATIONS AND THE ELDERLY: PROMISES, PROBLEMS AND PROSPECTS

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

BOYNTON BEACH AND MARGATE, FL, APRIL 1, 1986

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CONTENTS

MORNING SESSION

MEMBERS' OPENING STATEMENTS

Page
Chairman Dan Mica 1
Rick Boucher 4

CHRONOLOGICAL LIST OF WITNESSES

Panel One—Federal and State Officials:

- George Holland, Regional Administrator, Health Care Financing Administration 6
- Clyde Galloway, Florida Insurance Commissioner 10
- Alice Skaggs, director, Palm Beach County Office of Consumer Affairs 11

Panel Two—HMO Representatives:

- Dr. Jay Sanders, executive vice president for medical affairs, International Medical Centers; accompanied by Stephen Cohen, executive vice president and chief financial officer, Dr. James Vance, regional medical director, Palm Beach County, and Art Auer, regional director, Palm Beach County 26
- Robert Wilson, general manager, Palm Beach Regional Office, Av-Med Health Plan 51

Panel Three—Consumers:

- Rita Kolsin, West Boca Raton, FL 76
- Eileen Rundle, Boynton Beach, FL 79
- Kathleen Moyer, Palm Spring, FL 80

Panel Four—Medical Profession:

- Lee A. Fischer, M.D., past president, Palm Beach County Medical Society. 84
- Milton Tignor, M.D., president-elect, Palm Beach County Medical Society. 85
- Rodney Dorsette, administrator, Doctors Hospital, Lake Worth, FL 90

AFTERNOON SESSION

MEMBERS' OPENING STATEMENTS

Chairman Dan Mica 99
Rick Boucher 105

CHRONOLOGICAL LIST OF WITNESSES

Panel One—Federal and State Officials:

- George Holland, Regional Administrator, Health Care Financing Administration 106
- Clyde Galloway, Florida Insurance Commissioner 108

Panel Two—HMO Representatives:

- Dr. Jay Sanders, executive vice president for medical affairs, International Medical Centers; accompanied by Stephen Cohen, executive vice president and chief financial officer 118
- Robert Wilson, general manager, Palm Beach Regional Office, Av-Med Health Plan 150
- Richard Portnoy, chairman, Preferred Risk Systems 152

Panel Three—Consumers:

- Myer Dworkin, Boca Ratan, FL 162
- Mr. and Mrs. Irving Bleiweiss 164

Page
Panel Four—Medical Profession:
Victoria Alegre, office manager for private physician ... 170
James Rogers, M.H.A., assistant administrator, Northwest Regional Hospital, Margate, FL; accompanied by Dr. Neil Schultz ... 171
William G. Stafford, executive vice president, Broward County Medical Association, Fort Lauderdale, FL ... 173

HEALTH MAINTENANCE ORGANIZATIONS AND THE ELDERLY: PROMISES, PROBLEMS, AND PROSPECTS

TUESDAY, APRIL 1, 1986

House of Representatives,
Select Committee on Aging,
Boynton Beach, FL.

Morning Session

The committee met, pursuant to notice, at 9:30 a.m., in the Commission chambers, Boynton Beach City Hall, 120 E. Boynton Beach Boulevard, Boynton Beach, FL, Hon. Dan Mica (acting chairman of the committee) presiding.

Members present: Representatives Mica and Boucher.

Staff present: Diane Birnbaum, district administrator; John Gersuk, press assistant; Jill Benson, assistant; Nancy Ainger, assistant, Betsy Bellows, assistant; Andy Bouchlas, assistant; and Darcy Robinson, assistant; of Representative Mica's staff.

OPENING STATEMENT OF CHAIRMAN DAN MICA

Mr. Mica. The Committee on Aging will come to order. Let me first lay down a few ground rules and tell you what we are about to do here.

This is a duly organized hearing of the Select Committee on Aging. It has been authorized by Chairman Edward Roybal, for myself and Congressman Boucher to be here and take testimony that will be brought back to Washington as a part of an overall review that the Select Committee on Aging will be doing on a number of health concerns in this country.

First, if you have an individual problem or concern, we have some privacy forms that we can hand you to fill out, with places for your name and phone number on it, and so on, and we will process that. We cannot take individual testimony here today.

As in any hearing, be it in the field in Boynton Beach, FL, or Washington, DC, the panels are preselected so that we get some kind of a representative view of the problem we are trying to look into. But we are not, by any means, limiting anyone from submitting written testimony.

If you would like to make a statement and you are not on the panel, please fill the form out, prepare it and give to our office, and we will make it a part of the official hearings as we review these HMO's in the future.

If you don't have it with you at this time, without objection, I would like to ask unanimous consent that the record be left open for 7 days for any written testimony to be submitted.

I hear no objection, so that will be ordered, and we will leave the record open 7 days and you can submit to the office here in Boynton Beach, send it to Washington, or if you are going to be at the hearing down in Margate, any way you want. Within 7 days, if you will get it to us, it will be made part of the hearing.

With that, I would like to read an opening statement and introduce my colleague and thank him for taking the time to join us today. Representative Frederick Boucher is from Virginia and is also on the Select Committee on Aging. He has a long history of involvement in health-related issues and has proven himself an able and dedicated advocate for older Americans. I think he can help me in bringing back the message to Congress as to what kind of information we gain here today. So I am very pleased to have him here with us.

The purpose of the hearing, we think, is very clear: To examine the efficiency and the dramatic and relatively new health care concept known as health maintenance organizations. We, in short, want to know whether or not the system is working. Florida, with its large elderly population and disproportionate share of HMO consumers, is an ideal laboratory in which to study in the issue. As a matter of fact, we have about the fastest growing HMO's in the entire United States.

Our studies on the Aging Committee project that by 1990 the average senior citizen in this country will spend $2,583 a year on health care, and that would be nearly 19, almost 20 percent of his entire income. With medical costs already consuming 15 percent of the average senior's income, it is clear that HMO's are a viable health care alternative.

Just how viable is clear from national and statewide enrollment statistics. There are 480 operational HMO's nationwide today with over 20 million members. The enrollment figure is up from 14 million just 2 years ago, a 6-million increase in 2 years.

In Florida, right here in our own State, there are 32 HMO's with over 650,000 members, and that is a 50-percent increase—I repeat, a 50-percent increase—from 1984, just 2 years ago. And in that number may be part of the problems that we are going to examine here today.

There are about 70,000, that number may be a little old, but maybe 80,000 now, HMO members in just Palm Beach and Broward County; the vast majority of them are senior citizens. In fact, nearly 4 percent of all the Medicare beneficiaries nationwide, or over 1.1 million men and women, have turned to HMO's to control their out-of-pocket medical expenses.

Why the Federal Government involvement? Well, the Federal Government is footing the bill. The Federal investment in HMO's is staggering. In 1985 HMO's received more than $1 billion in Federal moneys, and we are determined to safeguard and oversee that investment.

Frankly, for months my office has been flooded with complaints and calls, and, of course, some praise and advice and information requests on HMO's. I will be blunt with you, HMO's have probably been the single largest area of concern that we have had in the last 6 to 8 months in our office. We have had a very staggering increase in the number of complaints, and that is one of the reasons why we are here today. I will concede that satisfied customers rarely contact their Congressmen. It is usually when you are not happy that you call our offices. But the volume of negative feedback demands that we look into this firsthand.

The most serious complaints are being investigated by my staff here and in Washington. We have had some allegations that I think will have to be handled not by a congressional office but probably by a law office, and that is unfortunate but, nonetheless, they are being looked into.

Before I release the results of a districtwide survey I conducted last month, I will say that HMO's as a health care concept are neither good nor bad, just as a hospital is neither good nor bad. Like all institutions, their quality hinges on the dedication of the men and women who staff them.

We had some 4,500 people respond to this survey, which is a very large number. Some of the quick points that I will mention here are that about a fourth, 24 percent, that responded said that they were dissatisfied with HMO's. Now, that means that two-thirds, three-quarters, were indeed satisfied, but that is a substantial minority that is dissatisfied.

One alarming statistic here, and one which we hope to talk a little bit about with our witnesses, in fact, a great deal about, is: "Does your HMO provide prompt payment of doctor bills." Fifty percent said, "No."

"Does your HMO provide prompt payment of hospital bills?" Fifty-four percent said, "No."

So we are finding some major concerns with the payment schedule and the payment efficiency, if you will, of HMO's.

The rest of the 10 questions that we asked are available for the press and I think copies are available for anyone who would be interested. On the surface of it, this survey demonstrates that a majority of HMO members are satisfied with the quality of care they receive. I am delighted that this is the case. But what concerns me is the substantial minority that is deeply dissatisfied with HMO care.

We are not here today to praise or condemn HMO's. We are here to learn whether a multibillion-dollar health care system that affects 20 million Americans is as efficient as it should be.

When a Social Security office or a veteran's office isn't responding or isn't handling people appropriately, our complaints start to skyrocket. And in the last 6 months our complaints on HMO's have really hit the ceiling. So that is why we are holding this hearing today.

Our oversight will not stop here. Congress and the Aging Committee will continue to monitor HMO's to assure that members get what they pay for. I also would like to announce that I have established a special "HMO Hotline" in my office to collect additional information on HMO's. The hotline can be reached by dialing 732-4002.

[The survey submitted by Representative Mica follows:]

1. Have you or members of your family disenrolled from an HMO because you were dissatisfied with the quality of care?

Yes, 24 percent; No, 76 percent.

2. Have you had problems enrolling or disenrolling?

Yes, 27 percent; No, 43 percent.

3. Are prescriptions readily available?

Yes, 87 percent; No, 13 percent.

4. Does your HMO provide prompt payment of doctor's bills?

Yes, 50 percent; No, 50 percent.

5. Does your HMO provide payment of hospital bills?

Yes, 46 percent, No, 54 percent.

6. Have you ever had difficulty obtaining test results?

Yes, 31 percent; No, 69 percent.

7. Does your HMO provide adequate referrals to appropriate specialists?

Yes, 64 percent; No, 36 percent.

8. Does your HMO provide adequate referrals to hospitals?

Yes, 70 percent; No, 30 percent.

9. Does your HMO provide adequate emergency care?

Yes, 68 percent; No, 32 percent.

10. Do you feel that your HMO has made exaggerated or deceptive claims about its services or benefits?

Yes, 43 percent; No, 57 percent.

Mr. Mica. Let me call on my colleague and say, again, I am very pleased to have you here. In order to have a field hearing we need at least two Members to be present, and we have asked Congressman Boucher to be with us here today. If he has any opening comments I would like to call on him at this time, and thank you again for being with us.

STATEMENT OF REPRESENTATIVE RICK BOUCHER

Mr. Boucher. Dan, thank you very much. It's a privilege to join you here in south Florida today to discuss a subject that is of great interest, not only to south Florida, but nationwide.

The use of HMO's is growning. There are 332 federally qualified HMO's today, and 28 HMO's were federally qualified in the first 10 weeks of this year alone. There are 20 million enrollees in HMO's nationally, and 80,000 participating physicians. Given those figures, I think it's clear that HMO's have already become a significant means of delivering health care services and substantial future growth is anticipated.

I would suggest that under ideal circumstances HMO's can be highly advantageous to their enrollees. They can ensure that patients receive all of the services that Medicare provides, with some additional services as well, such as eye care, prescription drugs, hearing aids, and dental services. Beyond that, those who enroll in HMO's theoretically are not subjected to coinsurance requirements or deductible charges that are often present in Medicare.

But under less than ideal circumstances, some problems in the administration of HMO's have been noted. There have been delays in processing information concerning both the enrollment and the disenrollment of HMO members. That leads to an uncertainty about who is responsible for the charges that are incurred during the lagtime between the time that a member signs up or disenrolls and the time that that information is transmitted to the HHS information base.

Prompt payment by HMO's of bills that are submitted has also been a very significant problem. Questions have sometimes been raised about the quality of services that are provided and whether or not the range of services actually meets the promises that are made by HMO's during the time that they are advertising for the signup of members.

It has been suggested that some HMO's will not pay for hospitals stays that are sufficient long to provide proper treatment.

Since HMO's are available in many parts of the country today as an alternative to Medicare, the Congress, as Dan has suggested, has a great interest in examining how well they are serving the needs of their members. We need to find out how well they are functioning and what can be done to address the problems that they are experiencing.

In south Florida you have what I suppose is the Nation's most intensive experience with the operation of HMO's, so it is highly appropriate that we are conducting this hearing today to draw on the experience that you have had.

I want to commend your Congressman, Dan Mica, for giving the Select Committee on Aging this opportunity to hear from you today. He is know in the U.S. Congress as a true friend of elderly Americans. That is a fact that his colleagues greatly appreciate, and I can tell you that he spends a great deal of time addressing your concerns in the House of Representatives.

So, Dan, I want to commend you for having this hearing today and for giving me the opportunity to participate with you in hearing from our witnesses.

Mr. MICA. Thank you very, very much.

At this time I would like to call our first panel to the table, and that would be George Holland, the regional Administrator of Health Care Financing Administration; Clyde Galloway, Florida insurance commissioner, and Alice Skaggs, director of the Palm Beach County Office of Consumer Affairs.

While they are taking the table, I would like to introduce my staff and tell you the fact it's a miracle we have them all here. One of them had an accident coming in on I-95, and she's still here. Darcy Robinson. raise your hand; we are glad to have you with us this morning, particularly this morning.

Ms. ROBINSON. Thank you, Mr. Chairman.

Mr. MICA. Jill Benson. all from my Boynton Beach office; Nancy Ainger, Nancy, raise your hand.

Ms. AINGER. Thank you, Mr. Chairman.

Mr. MICA. And Betsy Bellows, who has been responsible for coordinating our entire HMO hearing process in south Florida, from my Boynton Beach office.

Diane Birnbaum, who is our chief of staff in our Florida office, has helped handle all of these calls. I appreciate all the good work you all have done.

Andy Bouchlas is here, who has been a tremendous assistant in helping to coordinate everything, so I appreciate that. John Gersuk is here from my Washington office, who has helped oversee the survey from Washington and the coordination with the Aging Committee, thank you, John.

OK. Thank you all.

Let us just start in the order that I have called you.

Mr. Holland, you the regional Administrator for the Health Care Financing Administration. We'll start off with you and proceed right down the line. When you are finished, we will proceed with questions.

Let me invite you to summarize your testimony, if you would like. We have your written statements, I think, from each of you. Then we will move right into questions.

PANEL ONE—FEDERAL AND STATE OFFICIALS: CONSISTING OF GEORGE HOLLAND, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; CLYDE GALLOWAY, FLORIDA INSURANCE COMMISSIONER; AND ALICE SKAGGS, DIRECTOR, PALM BEACH COUNTY OFFICE OF CONSUMER AFFAIRS

STATEMENT OF GEORGE HOLLAND

Mr. **Holland**. My name is George Holland, and I am the regional Administrator of the Health Care Financing Administration. I am pleased to be here to discuss the administration of the HMO Program under Medicare.

Medicare payment to HMO's has been authorized since the program's inception. Initially the prepayment authority was restricted to part B. Prepayment organizations were permitted to receive 80 percent of their reasonable costs. HMO's could also elect to bill Medicare on a fee-for-service basis. Neither approach was consistent with the operating philosophy of HMO's: that is, to accept in advance a fixed per capita payment regardless of the medical services actually rendered.

With the Social Security Amendments of 1972 some progress was made in providing a reimbursement mechanism consistent with HMO operations. In addition to a cost-based reimbursement option, a modified risk basis option was made available. Under these contracts the plan shared equally with Medicare in the savings it achieved up to 20 percent of your total payments. However, payment was still made retrospectively and the final payment was often not settled until years after the services had been rendered.

In 1978, HCFA began to use its demonstration authority top develop prospective risk basis contracts. Those demonstrations led to the enactment in the Tax Equity and Fiscal Responsibility Act of 1982 of permanent authority for risk-sharing contracts for HMO's and competitive medical plans at 95 percent of the projected average per capita cost to Medicare for enrollees in the same geographic area under fee for service, that is, what is known as the average adjusted per capita cost. Under these TEFRA contracts, if the average payment rate is more than what the plan would charge, using its own commercial premium methodology, for the Medicare benefit package, that is, the plan's adjusted community rate, the organization cannot keep the difference. Generally, plans use these funds to provide Medicare enrollees with additional benefits, a reduction in premium, or some combination of the two.

We firmly believe that the availability of these risk contracts is a historic turning point for Medicare. It marks a decisive move away from intrusive regulatory schemes for controlling costs to an approach that instead utilizes increased competition and consumer choice. It is through capitation that we will succeed in controlling costs while still providing quality care.

We began signing contracts on April 1, 1985. As of March 14 of this year we signed 118 risk contracts with organizations in 28 States, covering over half a million enrollees. An additional 70 contracts which would enable us to offer Medicare beneficiaries in 9 other States an HMO option are pending.

Today, even with our tight budget environment, beneficiaries enrolled in HMO's are receiving both Medicare benefits and benefits not otherwise covered by Medicare, frequently for less than the average cost sharing under fee for service. We believe that this is an indication that everyone, the beneficiaries and the Federal Government, win with capitation.

Since it first entered into a contract with HCFA in June 1981, there has been considerable controversy surrounding the performance of International Medical Centers, IMC's. Given that IMC has the largest Medicare enrollment of all TEFRA HMO's, one would expect it to have more administrative problems than smaller plans. In the past, as these problems have emerged and have been brought to IMS's attention, they, in most instances, have been resolved.

Recently, the FBI and the office of the inspector general of the Department of Health and Human Services seized the records from two clinics operated by IMC through a subcontractor in Davie and Fort Lauderdale. The inspector general was investigating allegations from current and former clinic employees of health screening of potential enrollees and of fraudulent billings on the part of IMC subcontractors.

Clearly, this situation is extremely serious. In addition to the obvious potential violation of the contract with Medicare, this case involves allegations of fraud and conspiracy. Although an incident involving potential criminal actions by a subcontractor has not occurred before, IMC has had a history of administrative and financial problems with its subcontractors. In the past, IMB has explained these problems by blaming the subcontractors, comparing it to a "bad apple." Over time, however, with each new incident, this explanation becomes less convincing and one instead has to question whether IMC has the competency to effectively and efficiently manage its vast network of subcontractors. If it does not have this capacity, IMC's continued participation as a TEFRA HMO is in doubt.

It is equally clear to me, however, that IMC's problem is unique and is not an indication of the state of the Medicare HMO Program. IMC is unique not only because of its size but more importantly because of a crucial difference between IMC and other TEFRA HMO's.

As you are aware, one of the qualifications that must be met in order to have a risk contract with HCFA is that a plan must have at least 50 percent of its enrollment in commercial business. This provision was put in TEFRA in order to assure that an HMO demonstrated that it could meet the rigors of the market before it would be eligible to enter into a contract to provide services to Medicare enrollees.

To be able to attract and retain commercial business, the plan would have to demonstrate that it can deliver high quality services, has effective medical and financial management, and has good relations with the provider community. If a plan cannot meet the demands of the market, it cannot enter into a contract with HCFA.

As you know, IMC first entered into a contract with HCFA on a cost basis. The 50-percent rule did not apply at that time, and when TEFRA was enacted IMC, which was participating in Medicare's HMO risk reimbursement demonstration, had Medicare enrollment that was well above 50 percent. When HMO's in the demonstration were being converted to TEFRA contracts, a 3-year administrative waiver was granted to IMC and two other HMO's to give them time to increase their commercial enrollment. The intent of the waiver was to keep Medicare beneficiaries already enrolled in these plans from suffering a disruption in their health care arrangements.

In order to limit IMC's growth under the waiver, HCFA's Acting Administrator recently informed IMC that it will not be able to expand into jurisdictions beyond those covered in the HMO demonstration without meeting the 50-percent rule in these areas. In addition, I, as HCFA Administrator, recently asked IMC to prepare a plan within 30 days detailing the steps it will take in order to come into compliance with the 50-percent rule by the time the waiver ends in March 1988. I will be closely monitoring progress against this plan.

As you are aware, Secretary——

Mr. MICA. Mr. Holland, may I just interrupt. This is the first chance we have had to review your testimony. When did you recently notify IMC?

Mr. HOLLAND. Recently; a letter went out last week on this.

Mr. MICA. Last week.

Mr. HOLLAND. Right. As you may be aware, Secretary Bowen recently approved the transfer of the Office of Health Maintenance Organizations from the Public Health Service into the Health Care Financing Administration. OHMO handles applications by HMO's that wish to become federally qualified.

An HMO must meet the tests required for Federal qualifications before it can participate in the Medicare Program. The Secretary believes this transfer will accomplish the following: Improve the operations of both the HMO Program and Medicare HMO contracting; give wider visibility to the Administrator's efforts to promote capitation programs and facilitate communications with a broader base of organizations interested in applying for Medicare HMO contracts.

Now, one of HMO's first projects after the transfer will be to conduct a vigorous review of IMC operations to determine if they are still in compliance with the requirements for Federal qualification. The OMHO review will examine areas such as quality, availability and accessibility of services; financial viability and stability; grievance procedures; marketing techniques; enrollment/disenrollment procedures; medical management, and the adequacy of IMC monitoring of its contractural relationships with the subcontractors.

Where problems are uncovered IMC will have 30 days to develop a remedy or face having its federally qualified status revoked.

In addition to this effort by OHMO, we plan to utilize the services of a medical review/quality assurance contractor to review the activities of certain IMC subcontractors in regard to quality issues. Also, my staff from Atlanta will be increasing its oversight of IMC and its subcontractors.

During the next few months we will continue to closely monitor the performance of IMC. Our highest priority is to assure the quality of care afforded our beneficiaries enrolled in HMO's. We are prepared to take whatever steps are necessary to ensure that this plan meets the requirements of its contract with the Medicare Program.

We firmly believe that our capitation program is working to the benefit of both our beneficiaries and the Federal Government. Our continued progress in this voluntary program depends on maintaining the confidence of Medicare enrollees. We will continue to work with Congress, beneficiary groups, and the provider community toward the and of strengthening that trust.

I thank you for the opportunity to discuss these issues with you.

Mr. **Mica**. Thank you.

Let me make a couple of announcements here.

First, I want to apologize to those who have friends waiting outside. I understand we had 50 to 100 people turned away, and there's not much we can do. If we have another hearing we'll get a larger meeting room.

Also, again, we have had a few notes up here that people would like to mention individual cases and have individual concerns. Please give any personal problems to our staff here, and they will show you a form that you can sign and we can proceed in that way.

Let me just caution the public witnesses: I would say that it is not appropriate, unless you feel you have very strong legal grounds, to mention doctors' names or specific problems at this table. You do have immunity at this table, but not beyond this point.

So, for those who are going to testify, I would just talk about the general case and not talk about specific names.

Thank you Mr. Holland.

Mr. **Holland**. Thank you.

Mr. **Mica**. Mr. Galloway, I am going to ask that you at least try—and I hope this isn't too much of an inconvenience, but the sound system might be a little bit better up here at the podium and the public could also see you; maybe it will help out a little bit on both things.

We'll try one. If it works here, we'll continue there; if not, we'll go back to the table.

Again, let me ask you to summarize. Let me tell each of you our problem. We are going to take all of the written testimony, which is just as important as the oral testimony, but we do want to ask some questions, and unless you summarize we won't get into that.

We have read almost everyone's statement in advance, except the one we just heard, we just got that this morning, and part of yours, and we have an understanding of part of your testimony. But please summarize so that we can get into the questions.

STATEMENT OF CLYDE GALLOWAY

Mr. GALLOWAY. Thank you, Congressman. On behalf of Commissioner Gunter, I would like to express the appreciation of the Department to be invited to this hearing.

As you know, the HMO industry in the State of Florida is regulated concurrently by two agencies; the Department of Insurance and the Department of Health and Rehabilitative Services.

The department of insurance is responsible for the financial oversight and things that relate to the operation of the HMO. The HRS agency is in charge of the medical quality of care issues which come up in the regulation of this growing industry.

The HMO industry in the State of Florida is fairly young, as industries go, in that it was first regulated or authorized to be regulated back in 1973. From 1975, with a total of four HMO's in operation in Florida, the growth began. In 1980, Florida had a total of eight HMO's that were licensed to do business in the State. Then the industry took off. In 1986, we currently have 38 licensed HMO's, and we have 19 pending applications which should be reviewed during this year.

Those 38 HMO's serve a population of somewhere over 750,000 Floridians. This alternative health care delivery system is becoming a viable industry which has to be reckoned with. There are problems associated with it. The Department itself is currently reviewing somewhere between 400 and 450 complaints from individual subscribers, doctors that are associated with the HMO's that are providing it, and other agencies that have gathered information and submitted it to the Department.

The Department attempts to review all complaints that come through. Some of the complaints that relate to the quality-of-care issues are not within our jurisdiction and we do not have the staffing capabilities to handle those. However, we do work jointly with HRS in an attempt to try to resolve those problems.

The problem areas basically can be summarized into seven basic areas. There is still somewhat of a problem, but it is lessening each year with the conceptional understanding of how HMO's work. It is not the standard mechanism that the general public had been used to, but the concept is being accepted better by the citizenry in this State.

We have experienced some advertising problems, but those problems are diminishing and we are attempting to work those problems out. One of the largest problems that we have experienced is an enrollment/disenrollment problem within the Medicare-HCFA Program. Another issue, of course, is the quality of care.

Three areas which we, as the Department of Insurance, try to safeguard and attempt to monitor are the financial capabilities and adapting to this monumental growth, compliance with both Federal and State regulations, and review of the provider and subscriber agreements as submitted to the Department.

Those are the basic areas that we have problems with, and I would open myself up to questions at this point.

Mr. MICA. Thank you, Mr. Galloway. We won't get into questions right now; we will finish the panel and then question the entire panel.

Our next witness is Alice Skaggs, director of the Palm Beach County Office of Consumer Affairs.

Ms. Skaggs.

STATEMENT OF ALICE SKAGGS

Ms. SKAGGS. Good morning. No one has greeted you yet from Palm Beach County, so permit me to do that and welcome you, both of you, and this subcommittee, to Palm Beach County, and express our gratitude and that of our citizens for your interest and efforts.

Thank you.

Mr. MICA. Thank you.

Ms. SKAGGS. I am Alice Skaggs, director of consumer affairs for Palm Beach County. I am here today to testify to the problems my office has experienced through complaints against HMO for the aged. Basically, the complaints concern: Inability of the HMO member to get disenrolled; lack of response from HMO to consumer complaints; extreme delays in payment of claims, and the inadequacy and ineptness of IMC management in their recordkeeping, an example of which is in the submissions to the committee for the record.

The misrepresentations previously made by IMC that all hospitals in the country would accept IMC patients; the representations that should a patient require the care of a specialist, that IMC had numerous specialists in various fields that the patient could be referred to. That all too often proved not to be the case. The representations that emergency treatment could be acquired were the patient outside the State of Florida, all too often was not fact.

While I fully understand the enormous number of HMO enrollees in IMC in the State of Florida, and the apparent small percentage of complaints by comparison to this enrollment, and I also understand that no one can please everyone at all times, nonetheless, to the elderly HMO was literally represented as a panacea for all their health problems. Senator Chiles will contradict that with me.

It would appear that to properly and completely serve the elderly as formerly represented, IMC would have made every effort to handle all problems properly. The fact of the matter is that it would appear that something is badly lacking in their management, in view of the fact that it has become blatantly obvious to the Office of Consumer Affairs that their personnel turnover has been more than anyone should or could expect from a company this large. It has been said that if administration pays personnel peanuts they get monkeys. If administration hired the proper personnel and gave them the proper training before putting them into a position it would follow that their personnel turnover would be a great deal lower.

To hire personnel who allegedly have had Social Security experience is, in my view, inadequate. IMC HMO's is a totally different procedure, and office procedure should be taught to personnel certainly before they are put into a position.

I am submitting for the record examples of sworn statements, complaints, received in the Office of Consumer Affairs from consumers who are members of the IMC HMO, as well as copies of my letters to IMC and a few of their responses.

Mr. MICA. Without objection, the information supplied by Ms. Skaggs' office will be inserted in the record at this point.

Mr. BOUCHER. No objection.

[One example submitted by Ms. Skaggs follows. A further 107 pages of correspondence have been retained in committee files and may be viewed upon request.]

RECEIVED
JAN 11 1985
CONSUMER AFFAIRS

aca.

PALM BEACH COUNTY OFFICE OF CONSUMER AFFAIRS
301 N. Olive Avenue
Suite 301
West Palm Beach, FL 33401
Alice C. Skaggs, Director

JAN 11 1985
Date

COMPLAINT FORM

CLASSIFICATION

Complainant's Name W. LEWIS EVENDEN ([illegible]) Home Phone 793-5226

Address 11225 46TH ST NORTH W.P.B. Bus Phone

33411

Complaint Against HMO GOLD PLAN Phone 471-1333 ~~793-[illegible]0~~

(Address) GUN CLUB FAMILY MEDICAL CENTER

Person Contacted Title (ANNA CAIN 471 6969) (CLIENT RESOLUTION MGR MIAMI 1-800-521-4002)

Date of ~~Purchase~~ SERVICE FIRST WK OF MARCH 1984

Details of Complaint UNPAID MEDICAL BILLS

BILLS FROM PATHOLOGIST HAVE BEEN COMING TO ME FOR PAYMENT FOR SEVERAL MONTHS WHICH I HAVE TURNED IN AND EACH TIME WAS REASSURED IT WAS BEING TAKEN CARE OF HOWEVER IT HAS BEEN TURNED OVER TO A COLLECTION AGENCY. (DAN EDWARDS OF CREDIT CONTROL ALTAMONTE SPRINGS FLA. 831-8080)

THE LAST PAYMENT MADE TO THE PATHOLOGIST (DERRICK AND ASSOCIATES, ORLANDO FLA) WAS SEPT 5 1984 MADE BY HMO OUT MIAMI 1-800 533 5081.

ALSO HMO HAS A CORPORATE OFFICE IN [redacted] BOYNTON 1 800 551-4620 UNDER THE DIRECTION OF MARTHA BOWEN WHOM I HAVE SPOKEN TO. I BELIEVE THIS OFFICE HEADS THE COUNTY GROUP OF ABOUT 17 CENTERS

State of Florida
County of Palm Beach

Personally appeared before me the undersigned W. Lewis Evenden who first being duly sworn deposes and says that he/she has read and completed the foregoing Complaint Form and knows the contents thereof and that the same is true and correct to the best of his/her knowledge and belief

Sworn to and subscribed before me this 11th day of [illegible] 19 85

Helen E. Thompson
Notary Public, State of Florida

Notary Public, State of Florida
My Commission Expires Jan. 22, 1985

W. Lewis Evenden

W. Lewis Evenden have read and signed Complaint Form under oath and know the contents therein to be true to the best of my knowledge. I am aware that any false statements knowingly given are subject to the laws of perjury as provided for in the Laws of Florida 111.03 and could result in a fine and/or imprisonment upon conviction.

December 16, 1985

Douglass C. Smith
Claims Director
International Medical Centers
1505 N. W. 167th Street
Miami, Florida 33169

Re: Complaint of Kathryn M. Evenden vs.
International Medical Centers

Dear Mr. Smith:

I am enclosing a photocopy of your letter to me of February 1, 1985, reference the problem Mrs. Evenden was having with Credit Control at that time.

I am enclosing a photocopy of a letter from Credit Control to Mrs. Kathryn M. Evenden dated December 9, received in this office on December 16. This problem was supposedly corrected. Please take care of this matter immediately, and advise me that this has been done.

Sincerely,

Alice C. Skaggs, Director
Consumer Affairs Office

ACS:pl
Encs.

c.c. Mrs. Kathryn M. Evenden

RECEIVED
DEC 16 1985
COUNTY CONSUM
AFFAIRS OFFICE

CREDIT CONTROL
BOX 1290, ALTAMONTE SPRINGS, FL 32715
TELEPHONE (305) 831-6080

December 9, 1985

Evenden, Kathryn M.
11223 40th Street North
West Palm Beach, FL 33411

OWED TO: Derrick and Associates BALANCE DUE: 388.00

ACCOUNT NO.: WPE00292

Although a claim for payment of services rendered by our client was submitted to your HMO, they have failed to pay the full amount due on your account.

Because of it's delinquency, your balance must be paid in full to my office within ten days if you wish to protect your credit record.

While your HMO may reimburse you, depending on the terms of your HMO agreement, you are personally responsible to our client for payment of your obligation.

Avoid further collection activity by sending full payment to my office today.

Sincerely,

John Liddell

UNIT MANAGER

HMO

A SUBSIDIARY OF UNIVERSAL CREDIT SERVICE, INC

January 16, 1985

Mr. Daniel F. Murray
Vice President Finance
International Medical Centers
1505 N. W. 167th Street
Miami, Florida 33169

Re: W. Lewis Evenden for Wife, Kathryn M. Evenden
vs. HMO-Gold Plus Plan

Dear Mr. Murray:

This office is receiving a number of calls concerning this type of matter of unpaid bills that have been pending for six months. I have three more complaints coming in of this nature.

Please advise me within ten days what the problem is, and also advise how you intend to correct this matter.

Sincerely,

Alice C. Skaggs, Director
Consumer Affairs Office

ACS:pl
Enc.

c.c. Mr. & Mrs. W. Lewis Evenden

International Medical Centers - HMO
Executive Offices: 1505 N.W. 167 Street • Miami, Florida 33169 • (305) 621-4222

DADE COUNTY
[illegible]

BROWARD COUNTY
[illegible]

PALM BEACH COUNTY
[illegible]

HILLSBOROUGH COUNTY
[illegible]

PASCO COUNTY
[illegible]

PINELLAS COUNTY
[illegible]

February 1, 1985

[illegible]
FEB 6 1985
COUNTY CONSUMER
AFFAIRS OFFICE

Alice C. Skaggs, Director
Consumer Affairs Office
301 N. Olive Ave.
Third Floor
West Palm Beach FL 33401

Dear Ms. Skaggs:

Re: W. Lesis Evendon for Wife,
Kathryn M. Evenden vs/HMO
Gold Plus Plan

I am in receipt of your letter dated January 16, 1985, as addressed to Mr. Dan Murray, Vice President. Your letter has been forwarded to this writer for an answer.

Please be advised that I have personally intervened, and have settled all past claims with Derrick and Associates of Orlando, Florida. They were using the Collection Agency of Credit Control in Altamonte Springs, and I have agreed to pay negotiated rate on their past bills which should suffice to clear all of the past claims within due time. Unfortunately many of the members have been individually billed and we can only address those as we pay the claims, but we have been assured that Credit Control will not continue to process any claims against the members for service date rendered of 2/3/85 and before. Hopefully this should clear the matter. Should you you have any questions on this particular case or other cases that you have, as regards to Derrick and Associates, please do not hesitate to contact this writer.

Yours very truly,

Douglass C. Smith
Claims Director

DCS/lp

BEST COPY AVAILABLE

February 8, 1985

Mr. & Mrs. W. Lewis Evenden
11223 40th Street, Norhh
West Palm Beach, Fl. 33411

Re: Complaint vs. HMO Gold Plus Plan

Dear Mr. & Mrs. Evenden:

I am enclosing a photocopy of Mr. Douglass C. Smith, Claims Director, response which is self-explanatory.

We trust we have been of assistance to you in this matter.

Sincerely,

Alice C. Skaggs, Director
Consumer Affairs Office

ACS:pl
Enc.

Ms. **Skaggs**. Thank you.

They are not responsive. These examples also include samples of their accounting methods, which I am sure you will find most inadequate under the circumstances.

Also, the latest example is a letter written to me by their newest claims director, who informed me that all of the previous claims sent had been mislaid or lost, and he requested that I send copies of those complaints to him personally. I complied with his request on February 25 and to date I have received no response.

Thank you for the opportunity to have appeared here today, and for the kind attention. Should there be any questions I shall be glad to answer them.

Thank you.

Mr. **Mica**. Let me start off by saying this, and this is a personal view. I have had experience reviewing HMO's for almost 20 years now, and I personally believe that an HMO is neither good or bad. It's like a hospital or a group practice of doctors; some are great and some are not so great and some aren't good at all. It depends on who runs them, how they are run, how they are set up and how they are arranged.

So the concept has been proven, I think, pretty solid around the Nation. In fact, some of my Washington staff belong to the Georgetown University HMO, and they have done an excellent job. Kaiser-Perminenti out in California for 20 or 30 years has done an excellent job.

Our purpose here today is not to demean or defame the approach of HMO's but to look into the problems that we see with the growth and the type of service and types of HMO's that are operating in our area.

I would start the first question here with Mr. Holland. I had not read your testimony before, but your testimony and, in fact, all two or three of the three witnesses talk about IMC. There are several HMO's operating in south Florida.

Can you tell us the number there are and why are you specifically talking about IMC? Is this an example of what is going on with all of them or are you saying that IMC is the one with most problems?

Mr. **Holland**. Yes; we have seven risk and three cost contracts in Florida. We are not getting anywhere near the volume of complaints from the other HMO's. What you have with IMC is atypical.

I think the main thing is that we granted the waiver and we don't have that 50-percent commercial side that we should have in an HMO to make it more viable and to compete in the marketplace. That is one of the big problems.

Mr. **Mica**. Do the others have a 50-percent waiver?

Mr. **Holland**. No, they don't have the waivers; they have the 50 percents. You see, as indicated under the demonstration, we allowed the 50 percent to exist. When we switched over to TEFRA and put them on a risk contract we gave them 3 years to catch up on their commercial side, to bring in the commercial enrollment so it would hit a 50—50 match.

Mr. **Mica**. What is the percentage now?

Mr. **Holland**. I believe it's 27 percent.

Mr. MICA. Twenty-seven percent?

Mr. HOLLAND. Right, on the commercial side.

Mr. MICA. And they have 1½ years to get the 50 percent?

Mr. HOLLAND. The waiver runs out in March 1988.

Mr. MICA. And you would suspend operations of HMO's if they didn't meet that?

Mr. HOLLAND. Well, they can't get in unless they do meet it under the risk contract, the 50—50 match.

Mr. MICA. I guess the point is what happens to the people who are already in the HMO IMC if it's only 27 percent; did I misunderstand you?

Mr. HOLLAND. We have over 50 percent Medicare enrollees and the mix is supposed to be 50 percent Medicare enrollees here and then 50 percent commercial to ensure that we get the competitive viable insurance plan.

Mr. MICA. And you are saying that——

Mr. HOLLAND. We have over 50 percent Medicare enrollees now and we are trying to pick up on the commercial side to hit the 50—50 and we are 27 percent commercial.

Mr. MICA. And this is specifically IMC, not the others?

Mr. HOLLAND. Right, it's atypical. Now, there are two others like that in the country. So it's not across the country and this is where we are having a lot of our problems.

Mr. MICA. No others in Florida?

Mr. HOLLAND. No.

Mr. MICA. Now you mentioned that you are going to be monitoring. I'm surprised here, frankly, that we are talking just about one. We intended to talk about HMO's in general, and it seems to be all IMC here, you mention that you are monitoring them to see if, indeed, they would meet three major criteria, and if it doesn't they cannot enter into a contract with you; is that correct?

Mr. HOLLAND. What we are doing, we moved over the Office Health Maintenance Organizations from Public Health, and this is one of the big reasons that we can do this. So we have additional staff and now they are under HCFA as of last Thursday or Friday, and they are going to come down here, I believe, the third week in April.

There are two things to accomplish. One is that IMC has requested an expansion into another country, they are going to check that out. And, two, they are going to do a very indepth review of all the items that I have mentioned under the existing contract to see if they are complying with their Federal qualification.

Mr. MICA. OK. The point that I am making is if they are not complying with Federal qualifications and we have 70,000 people as members, what happen?

Mr. HOLLAND. I am glad you brought that up. This is one of the difficulties and we would be more than happy to work with the Congress in trying to get some solutions.

A lot of people are very well satisfied with IMC. But we are in a situation now, if, in fact, we pull their Federal qualifications we could, in fact, terminate the contract, and this is always a possibility but we just have that option.

What we don't have are any sanctions in the law which we can impose on an HMO that is not functioning correctly such as monitors, civil penalties, which would be short of the wholesale termination of a contract, and that is one of the problems.

Mr. **Mica**. Well, I wasn't aware of that.

Mr. **Holland**. There's no in between.

Mr. **Mica**. It's either they comply or you pull the contract.

Mr. **Holland**. That's right.

Mr. **Mica**. And that's the situation we are in right now.

Mr. **Holland**. Right.

Mr. **Mica**. And you are looking for some legislation possibly to——

Mr. **Holland**. It would be very helpful. It could be sanctions of some sort to be put in. Say, under quality assurances could we in fact put something on our HMO saying, "You didn't pass" like we do on our Medicare contract, if they don't pass a certain standard? If we had those same things on HMO's it would be very beneficial.

Now we are tightening up on our regulations and our standards, and in the next contract that the HMO's sign across the country one of the big things will be the timely payment of bills. Frankly, we didn't have that in there but that will definitely be in all new contracts that are coming up for renewal.

Mr. **Mica**. Have you had an opportunity to look into the timeliness of payments for HMO's in South Florida?

Mr. **Holland**. Yes.

Mr. **Mica**. What have you found?

Mr. **Holland**. Again, IMC stands out as having a very poor track record; the other ones aren't that bad.

Mr. **Mica**. Are we talking about just efficiency and management in getting the checks out or are we talking about financial stability?

Mr. **Holland**. We are talking both, and that is why we want OHMO to come down here. What you have for is 185 to 190 subcontractors under IMC as a parent organizations. The subcontractors are responsible for paying the bills, and then IMC gives them their capitation payment once a month and then it's up to the subcontractor to in fact pay the specialist and the doctors. And this is extremely difficult to monitor for anybody, and that's one of the big problems.

Mr. **Mica**. The first question for you, and I have a hundred questions that you have already raised here but we won't be able to ask them all here. But you indicated that last week you sent IMC a letter of concern, of intent. Could you tell me about that?

Mr. **Holland**. I have two letters; one was indicating that we were concerned about their payment and also their moving toward the 50 percent, and I indicated that I, as regional administration, would be closely monitoring their progress. Also I wanted a plan within 30 days indicating to us how they were going to achieve their 50-50 mix by 1988, so we will be monitoring that on an ongoing basis.

Mr. **Mica**. I must say what you are telling us is very disturbing. In fact, it's far beyond what I had envisioned getting into in this hearing. But I think we will have to follow that very closely and we may have to ask for a full committee hearing in Washington to immediately proceed, because I think it would be disastrous to cut 70,000 people off from HMO care, but, at the same time, I think that the concerns you raised, if there are some financial instability or management problems, must be corrected.

Mr. Galloway, you mentioned 400 to 450 complaints; is that statewide?

Mr. Galloway. Yes, sir.

Mr. Mica. Can you break those down by area; are we talking about a majority coming from our area or a disproportionate amount?

Mr. Galloway. The majority would be from this area. I do not have those broken out by county.

Mr. Mica. Could you provide that for the record?

Mr. Galloway. Yes, sir. It would take a little time. We are not automated in Tallahassee yet but we can get it out for you, yes.

Mr. Mica. We would like to have a breakdown of the number of complaints as a percentage for each of the HMO's that you are reviewing and overseeing.

Mr. Galloway. Do you want that on a county basis or a statewide basis?

Mr. Mica. How many operators did we say we have here, 32 in Florida?

Mr. Galloway. Thirty-eight.

Mr. Mica. I would like to have the names of each one, the number of participants and then the percentage of complaints that you are handling of a serious nature.

You mentioned advertising problems. In our own survey, if I can find it here, we had asked a question about deceptive claims.

The question was: Do you feel that HMO's have made exaggerated or deceptive claims about services or benefits? Forty-three percent told us yes. What has been your experience on that?

Mr. Galloway. Today the Department has investigated only one case which came to an administrative action.

Mr. Mica. Only one?

Mr. Galloway. Only one, and that action was concluded before any formalized hearing was conducted. We investigated the allegations and a settlement was reached between the parties, the complainants, and the involved HMO's.

Mr. Mica. So you would not say that deceptive claims are a major problem?

Mr. Galloway. We have investigated on an ongoing basis the advertisements that come in and the complaints about them. To say that there is no problem might be stretching it a little far, but we do continue our review of them.

There is not a prefiling in the State. You advertise, basically, at your own risk. Once the advertisement is conducted, if it is later determined to be unfair or deceptive, then the Department has the latitude to act.

We have reviewed this area of operation of an HMO but the legislature, at this point in time, has not required presubmission before release as it does with some of the industries in the State.

Mr. Mica. Tell me, quickly, does your office have any concern over financial stability or management ability of any HMO's in the State?

Mr. Galloway. On an ongoing basis, we do review all the financial documents sent in by all the HMO's. There are some problem areas that we have perceived. One of the problems that we run into is that a lot of the HMO's are operated on a GAAP basis, whereas the statutory basis differentiates between some of the admissible assets.

We are currently in the process of reviewing some of those assets from an evaluation standpoint to determine the adequacy of them under the statutory method.

Mr. **Mica**. Is that a yes or no?

Mr. **Galloway**. It's kind of a yes and kind of a no. There are some problem areas which we are looking into. We have not seen a cash-flow problem at this point with any HMO in particular.

Mr. **Mica**. You have not seen a cash-flow problem with any HMO?

Mr. **Galloway**. Not as far as information reported to us.

Mr. **Mica**. All right. That's contradictory to what Mr. Holland said, but it may be that you don't have that information.

Ms. Skaggs, two points you made that I would like you to elaborate on, if you will.

You mentioned extreme delays in patient claims, and you mentioned point 4, to read from your statement:

"The inadequacy and ineptness of IMC management in their recordkeeping." Could you elaborate on those two points, and let me say again, and I invite each of you to mention if you have concerns, we have at least 3 HMO's operating in our area. There are concerns with others. I am somewhat surprised to see this all focused totally on IMC, although I know it is the largest.

Alice?

Ms. **Skaggs**. I have no complaints on the other HMO's, Congressman.

Mr. **Mica**. None at all?

Ms. **Skaggs**. None; not one. We handle 6,000 to 10,000 complaints a year, written sworn statements. I have none. Certainly that should be indicative to where the problem area is, I am sure.

Mr. **Mica**. Can you talk to us a little bit; you have none?

Ms. **Skaggs**. None. Zero, Dan; zero.

Mr. **Mica**. My own office tells me, and I just had a note that they reviewed our files and we have only had two in the last 8 months on anyone but IMC, and I wasn't aware that it was that lopsided. I am surprised.

Ms. **Skaggs**. Perhaps you understand why we are upset.

Mr. **Mica**. Extreme delays in payments of claims and inadequacy and ineptness of management; can you give us some of your rational behind those statements?

Ms. **Skaggs**. Yes. It's in the record for your information, sworn statements, copies of my letters to IMC. Extreme delays, being over a year for a payment. All sorts of delays, and they are all outlined there in that outline, evidence for you in your packet.

I personally believe, having been in the medical field and the health care field in the past, long past, as a matter of fact, being in an administration in addition to that, I said it correctly before that I think their whole problem is administration.

The gentleman next to me said that Tallahassee is not yet automated. Fine, I understand that reason; it's budgetary. However, IMC should never be budgetarily imparied from automation.

You will also find in your packet a copy of one of the accounting slips they sent to me; it's easy to find, it's a yellow legal page used sideways. There is no way in this world that they can possibly use an accounting system such as that for the enormous number of enrollees they have. Their personnel turnover, Congressman, is atrocious, absolutely atrocious.

Mr. **Mica**. Can you give me some idea of how you come to that conclusion; have you been dealing with a large number of people or——

Ms. **Skaggs**. The evidence given to you for the record will also prove that; yes, sir.

Mr. **Mica**. At this time I would like to call on Congressman Boucher for any questions he may have.

Mr. **Boucher**. Thank you very much, Mr. Chairman.

I want to thank the witnesses for their very helpful testimony this morning. In the interest of time I am only going to ask a couple of questions.

Ms. Skaggs, I was particulary interested in your testimony concerning the complaints that you have received, which indicates that all of your complaints have been directed against one HMO, admittedly the largest, but that you have had no complaints with regard to the others.

How many others are operating in this area, do you know?

Ms. **Skaggs**. I have no idea.

Mr. **Boucher**. Does anyone on the panel know the answer to that?

Mr. **Holland**. There are 7 risk and 3 cost; it would be 10.

Mr. **Boucher**. So you have a total of 10 HMO's.

Mr. **Holland**. Not federally risk or cost.

Mr. **Boucher**. Can you tell me what the enrollment figures are with respect to those 10 HMO's? I know that IMC is the largest, but what percentage of the total enrollment does it have?

Mr. **Holland**. IMC, well, their enrollment as to the end of March was 147,000, and I would guess on the others. I didn't have enough time to get that yesterday, but it would probably be 25,000 to 28,000 on the combined other 9.

Mr. **Boucher**. All right. So the nine others have more total enrollees than IMC; is that correct?

Mr. **Holland**. No; I'm sure it's the other way around. The 9 have probably 28,000 and IMC has 147,000.

Mr. **Boucher**. I see. So it is by far the largest and has the vast majority of the enrollees. Still it appears that some 28,000 enrollees are being treated reasonably well and are not dissatisfied with the services they are receiving. I think that says something about the basic concept of HMO's being a valid concept.

Ms. Skaggs, would you agree with that?

Ms. **Skaggs**. Congressman, I would even go so far as to say that I would agree that no matter how many complaints IMC has per capita, everyone is going to have complaints. No one walks on water and can please everybody all the time, but these are ridiculous and ludicrous and they are unnecessary.

No; I think it's small number, but my main problem, and frankly, if I were not in my position, I would probably go down and offer myself for administration, because they certainly need it.

Mr. BOUCHER. Let me ask about a couple of the areas where I understand problems have arisen in the general administration of HMOs.

The first of these is whether or not the services that are actually provided to beneficiaries equal the claims that are made and the promises that are made for service since public advertising to try to get people to sign up.

Do you find that the services actually provided are as broad as the claims that are made for those services during advertising?

Ms. SKAGGS. No, sir; and I recognize unfair and deceptive practices in advertising. But, very frankly, I left up to the Insurance Department because I thought that was their forte, it was out of my league.

Mr. BOUCHER. Mr. Galloway, would you care to comment on that?

Mr. GALLOWAY. The only complaint that we have carried forward in an investigation related to the use of affiliated providers that were not, in fact, providers from the standpoint of the advertisement and, again, that particular complaint was resolved before a hearing was necessary.

Mr. BOUCHER. So, generally, you have not had complaints coming before you, nor in your investigations have you found instances where the services actually provided were something less than the promises made during the advertising period.

Mr. GALLOWAY. To be quite frank with you, Congressman, our staff is not geared to the level that it should be in order to investigate all of those complaints. We have so many other complaints that relate to the payment of bills, and things of that nature, plus the staggering amount of pending applications that we have to review, that we don't have the staff capabilities to review all complaints that come about advertising.

Mr. BOUCHER. Let me ask one final question, and then we are going to need to move on to our next panel.

I have heard some people suggest that HMO's are now instituting diagnostic related groups to determine the length of hospital stays for particular illnesses.

Ms. Skaggs, you might want to comment on that, and the specific question that I have is whether, in your opinion, the stays that HMO's will pay for are long enough to provide proper treatment; and second, whether or not the stays that are provided for with HMO payments are greater than or less than the stays that would be provided for the same illness under Medicare.

Ms. SKAGGS. Congressman, I can only speak for this area—that is, Palm Beach County—from my own knowledge. To my knowledge, the diagnostic-related groups are a must in most hospitals, if not all of the hospitals, in Palm Beach County.

HMO has no leeway, they must pay for the DRG; however, when you have a couple of hours, I'd like to discuss the DRG with you—firsthand experience, calling for an amputation, a bypass, arterial bypass, and a massive heart attack and a minor heart attack. It happened in my case, to my husband. Boy, have I got a gripe.

Mr. MICA. Thank you very much, and I would like to ask the panel—well, I just do not think we are going to get back to questions, but I am going to leave the record open—Mr. Holland, in particular, you have raised a great number of questions, and I think that we are going to have to look at them on a national basis, if there are concerns here.

Mr. Galloway, I would just tell you this: If you can tell my good friend, Bill Gunter, we really need him to gear up to check out these types of problems, and if he does not have the authority or the jurisdiction, we need to find out who does.

Ms. Skaggs, we thank you very much. We thank each of you, and we will be submitting—I will be submitting some questions in writing for the full committee, because I think we have raised very, very serious concerns here.

Thank you very much.

The next panel consists of HMO representatives: Mr. Robert Wilson, general manager of Palm Beach regional office of Av-Med, an HMO; and Dr. Jay Sanders, executive vice president for medical affairs of IMC, also an HMO.

Let us proceed with Dr. Sanders from the IMC HMO, and Dr. Sanders, please feel free to summarize your statement, and let me note that your entire statement will be included in the record, and I understand we have additions that have just been submitted. I have not had the chance to look at them myself yet, but please proceed.

PANEL TWO—HMO REPRESENTATIVES: CONSISTING OF DR. JAY SANDERS, EXECUTIVE VICE PRESIDENT FOR MEDICAL AFFAIRS, INTERNATIONAL MEDICAL CENTERS, ACCOMPANIED BY STEPHEN COHEN, EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, DR. JAMES VANCE, REGIONAL MEDICAL DIRECTOR, PALM BEACH COUNTY, AND ART AUER, REGIONAL DIRECTOR, PALM BEACH COUNTY; AND ROBERT WILSON, GENERAL MANAGER, PALM BEACH REGIONAL OFFICE, AV-MED HEALTH PLAN

STATEMENT OF DR. JAY SANDERS

Dr. SANDERS. Good morning, Congressman Mica, Congressman Boucher, ladies and gentlemen. My name is Dr. Jay Sanders. I am the executive vice president for medical affairs of International Medical Centers, and I am accompanied this morning by Mr. Stephen Cohen, who is executive vice president and chief financial officer; Dr. James Vance, who is our regional medical director for Palm Beach County; and Mr. Art Auer, who is our regional director of Palm Beach County.

I would like to thank you, on behalf of IMC, for inviting us to participate in this hearing. We at IMC are committed to providing the highest quality medical care to our members——

Audience MEMBERS. No. No.

Mr. SANDERS [continuing]. And we welcome the opportunity to share our experience with you——

Mr. MICA. Dr. Sanders, would you suspend for a moment. We want to conduct this in an orderly fashion, and we will try to ask the kind of questions that will be helpful for all of us to solve any problems we have. But if we start letting this get out of hand now, it is going to create more problems. So, let us just stop right here. Please proceed, Dr. Sanders.

Mr. **Sanders**. OK. We actually welcome the opportunity to share our experience with you and to participate in efforts to improve the Medicare HMO Program.

IMC is a federally qualified HMO with approximately 200,000 members, including about 145,000 Medicare members. IMC was the first HMO in Florida to enter into a demonstration with HCFA for covering Medicare beneficiaries on a prepaid risk basis in August 1982.

IMC delivers health care services both through facilities wholly owned and operated by IMC, and through contracts with private physician groups who provide services in their own facilities. We have nearly 200 delivery locations throughout the south Florida, Tampa, and the Palm Beach areas. Contracting groups, which we refer to as affiliated providers, serve our members directly, and if a service cannot be provided directly, arrange for the service, generally, through a specialist.

At IMC we have one of the most comprehensive quality-assurance systems in the Nation. It is the only program in which independent external audits are carried out of what the physician does in his private office. Patient charts are examined and compared with disease-specific criteria to ensure that the most up-to-date quality care is being provided. In addition, a unique hospital audit system has been implemented that determines whether the cause of hospitalization was secondary to inappropriate care within the ambulatory setting. This type of audit was going to be implemented by the Federal Government through the PRO program for all HMO's, but it has not yet been done, so we have been doing this for the past year and a half. We have been invited, in addition, to present our system at the annual meeting of the Group Health Institute in Washington.

We are aware that there has been criticism of our organization in the bills payment and claims processing area. Let me explain our process.

IMC has historically processed hospital claims within a 30 day period, and our most recent review of the claims indicated that almost 90 percent of our inpatient claims were processed within the 30-day window. We did, however, experience some delays in December 1985 due to a larger than anticipated volume of claims. We are implementing a new state-of-the-art, fully automated claims system which, we are confident, will eliminate this problem.

In addition, in late 1984, we also began to see some delays in payments from a small number of our affiliated providers. In January 1985, IMC initiated audits of providers where we had evidence of problems. We developed procedures to allow us to step in and make payments directly, should the need arise. This 72-hour-turnaround claims processing system allows us to pay overdue referral bills as soon as they come to the attention of IMC and are verified.

More importantly, we are working with our affiliated providers to help them understand their financial needs and requirements. We have significantly strengthened the management of the IMC division responsible for network operations. In a number of cases, we have assumed responsibility for managing the centers; and in a few cases, when we felt it was necessary, we have not hesitated to terminate the provider's contract. In these cases, we have made arrangements for the orderly transfer of affected members to other IMC centers.

This experience has led us to proceed more cautiously, and when we bring new affiliated providers into the system, we are setting up a system in which we pay claims for them for the services they do not provide directly. We intend to do this with each new provider. In addition, we have assumed responsibility for payment for purchased services of 19 affiliated provider centers and have notified 11 others of our intent to take over this responsibility.

There have been recent allegations against affiliated centers. We do not, of course, disassociate from our affiliated providers. They are part of our health care delivery system and a part of IMC. We are proud of the performance of almost all of our affiliated providers, but a few need to improve, and we have taken and are taking strong administrative action to make improvements.

Late last week we were made aware of allegations of violations of Federal law by individuals who operate two of our affiliated medical centers. We are very concerned when any individual within the IMC system violates any provision of our contract with the Government or any law of the State of Florida or the United States relating to our contract, and IMC will take all appropriate legal action against the individual. IMC has a very clear policy prohibiting these kinds of actions, and I would like to offer, for the record, materials relevent to this policy.

Mr. Mica. Without objection, that information, which was just provided, will be accepted for the record.

I note that there is one document—I have not read it all—I note that there is one document dated yesterday; were some of these plans or these approaches just conceived in the last few days?

Dr. Sanders. No; I think you need to realize that the allegations against these two affiliated provider sites actually occurred 1 week ago. One of the questions which arose is whether or not, from a legal standpoint, since these were simply allegations at the time and there has been no judgment that has been brought to bear—is whether or not we have the right at that point in time, from a contractual standpoint, to disassociate; however, we have made a determination within that week's period of time that it would be for everybody's benefit for us to initiate disassociation.

Mr. Mica. And that was just done yesterday.

Dr. Sanders. That is correct. And this was brought to our attention, I think, approximately a week ago.

With respect to marketing, we are making significant efforts to enroll more non-Medicare members and, in fact, we have just brought on a new executive vice president for marketing who has substantial experience in the commercial sector, Mr. Richard Mastaler, formerly with Humana, Inc. Mr. Mastaler's top priority will be to develop and implement a plan to increase the level of commercial enrollment.

In summary, IMC has established an extremely broad-based, high-quality health care delivery system for its members.

Several years ago, we began as an experiment. While no undertaking as new and innovative as this can proceed without some problems, these are being addressed effectively and responsibly.

An independent study of patient satisfaction, prepared in September 1985 by a University of Miami researcher, confirmed that 92.9 percent of our members are satisfied with the services provided by IMC.

We believe we have demonstrated that both Medicare enrollees and the Federal Government can benefit from HMO contracts. This experience has also demonstrated the large demand for and wide acceptance of such a system among the Medicare population. The overwhelming majority of our 145,000 Medicare members are very pleased with their health care system.

We will be happy to respond to any questions.

Mr. MICA. Thank you.

[The prepared statement, along with additional material, submitted by Dr. Sanders follows:]

PREPARED STATEMENT OF JAY H. SANDERS, M.D., EXECUTIVE VICE PRESIDENT, MEDICAL AFFAIRS, INTERNATIONAL MEDICAL CENTERS, INC.--HMO

Good morning, Congressman Mica, and ladies and gentlemen. My name is Dr. Jay Sanders, Executive Vice President for Medical Affairs. I am accompanied by Stephen Cohen, Executive Vice President and Chief Financial Officer, Dr. James V. Vance, Regional Medical Director for Palm Beach and Broward County, Mr. Art Auer, Regional Director of Palm Beach County.

I would like to thank you, on behalf of IMC, for inviting us to participate in this hearing. We at IMC are committed to providing the highest quality medical care to our members, and we welcome the opportunity to share our experience with you and to participate in efforts to improve the Medicare HMO program.

IMC is a Federally qualified HMO with approximately 200,000 members, including about 145,000 Medicare members. IMC was the first HMO in Florida to enter into a Demonstration with HCFA for covering Medicare beneficiaries on a prepaid risk basis in August of 1982.

IMC delivers health care services both through facilities wholly-owned and operated by IMC and through contracts with private physician groups who provide services in their own facilities. We have nearly 200 delivery locations throughout the South Florida, Tampa and Palm Beach areas. Contracting groups, which we refer to as affiliated providers, serve our members directly and, if a service cannot be provided directly, arrange for the service, generally through a specialist. Our network of providers consists of approximately 2,000 health care providers. IMC also contracts with 29 hospitals and facilities for inpatient care.

BENEFITS

IMC provides one of the most enriched benefit packages to its Medicare members in the Nation.

IMC's Gold Plus Plan provides all benefits covered by Medicare, and substantial other benefits not covered by Medicare at no cost to its members. The average value of benefits over and above Medicare covered services furnished each Medicare member under our contract is $54.47 a month. In 1986 this will represent a total of over $8 million a month, or approximately $100 million per year in additional benefits which will be provided to our members. Such additional benefits include the elimination of coinsurance and deductibles; unlimited hospitalization; outpatient prescription drugs; and hearing, vision, and dental care.

A Harvard University study group found that the amount Medicare beneficiaries had to contribute for health care during the decade has risen 50% faster than their income, clearly the kind of program IMC projects as one which is desperately needed by many of our senior citizens, who after went without care because they could not afford these out-of-pocket costs.

QUALITY ASSURANCE

A major goal in our system is to obtain the highest quality of physician. A poor physician will not only provide lower quality care but produce higher, not lower cost. It is both cost-effective and quality-effective to obtain the very best physicians.

At IMC we have one of the best quality assurance systems in the nation. It is the only program in which independent external audits are carried out of what the physician does in his private office. Patient charts are examined and compared with disease specific criteria to ensure that the most up-to-date quality care is being provided. In addition, a unique hospital audit system has been implemented that determines whether the cause of hospitalization was secondary to inappropriate care within the ambulatory private physician's office. This type of audit was going to be implemented by the Federal Government through the PRO program for all HMOs but it has not yet been done. We have been invited to describe our system at the annual meeting of the Group Health Institute in Minneapolis.

We are aware that there has been criticism of our organization in the bills payment and claims processing area.

Let me explain our process. IMC has historically processed hospital claims within a 30-day period, and our most recent review of the claims indicated that almost 90% of our inpatient claims were processed within the 30-day window. We did, however, experience some delays in December of 1985 due to a larger than anticipated volume of claims. We are implementing a new state-of-the-art, fully automated claims system which, we are confident, will eliminate this problem.

In late 1984, we also began to see some delays in payments from a small number of our affiliated providers. In January of 1985, IMC initiated audits of providers where we had evidence of problems. We developed procedures to allow us to step in and make payments directly, should the need arise. This 72-hour-turn-around claims processing systems allows us to pay overdue referral bills as soon as they come to the attention of IMC and are verified. The system is in place and working, although it has created its own problems, namely some number of duplicate payments.

More importantly, we are working closely with our affiliated providers to help them understand their financial needs and requirements. We have significantly strengthened the management of the IMC division responsible for network operations. In a number of cases we have assumed responsibility for managing the centers; and in a few cases, when we felt it was necessary, we have not hesitated to terminate the provider's contract. In these cases we have made arrangements for the orderly transfer of affected members to other IMC centers.

This experience has let us to proceed more cautiously and now when we bring new affiliated providers into the system, we pay claims for them for the services they do not provide directly. We intend to do this with each new provider. In addition, we have assumed responsibility for payment for purchased services of 19 affiliated provider centers and have notified 11 others of our intent to take over this responsibility.

RECENT ALLEGATIONS AGAINST AFFILIATED CENTERS

We do not and cannot disassociate ourselves from our affiliated providers. They are part of our health care delivery system and a part of IMC. We are proud of the performance of almost all of our affiliated providers. A few need to do better and we have taken and are taking strong administrative action to make improvements.

Late last week we were made aware of allegations of violations of Federal law by individuals who operate two of our affiliated medical centers. We are very concerned when any individual within the IMC system violates any provision of our contract with the Government or any law of the State of Florida or the United States relating to our contract, IMC will take all appropriate legal action against that individual. IMC has a very clear policy prohibiting these kind of actions, and I would like to offer for the record materials relevant to this policy.

Because of the serious nature of the allegations, we must act immediately to protect the interests of our members and have taken several measures to assure that IMC members who receive medical care through these centers will have access to and receive high quality medical care:

1. We have terminated our contract with these two centers effective March 31. IMC members are being notified and we have arranged for an orderly transfer to other centers so that their care is not interrupted.

2. Mr. Miguel Recarey, Jr. sent a letter to all our affiliated providers on March 31, 1986 reaffirming this policy and reminding providers that IMC will terminate its contract with any provider found out of full compliance with these rules. I would like to insert this letter into the record.

3. We are developing a proposal for The Health Care Financing Administration to furnish us with fee-for-service claims data on our new members which would identify cases where inappropriate services may have been provided prior to enrollment.

4. A previously planned system for in-depth post enrollment interviews with new members will be implemented on an accelerated schedule.

5. We will contact the U.S. Attorney's Office and other Federal Offices and attempt to secure their agreement to accept cases for investigation and possible criminal prosecution from IMC where IMC has discovered evidence of any violations.

MARKETING

We are making significant efforts to enroll more non-Medicare members and in fact, we have just brought on board a new Executive Vice President for Marketing who has substantial experience in the Commercial sector, Mr. Richard Mastaler, formerly with Humana, Inc. Mr. Mastaler's top priority will be to develop and implement a plan to increase the level of commercial enrollment.

IMC's dramatic growth in Medicare enrollment since the beginning of the demonstration in August, 1982 has led to some systems problems and in light of this, we have deemphasized marketing in order to develop the administrative infrastructure necessary to respond to this growth. Generally, IMC's Medicare enrollment has leveled off and remained relatively stable during the last year growing from 110,000 Medicare members in January, 1985 to 137,000 in January of 1986.

In summary, IMC has established an extremely broad based, high-quality health care delivery system for its members.

Several years ago, we began as an experiment. While no undertaking as new and innovative as this can proceed without some problems, these are being addressed effectively and responsibly.

An independent study of patient satisfaction prepared in September of 1985 by a University of Miami researcher confirm that 92.9% are satisfied with the services provided by IMC.

We believe we have demonstrated that both Medicare enrollees and the Federal Government can benefit from HMO contracts. This experience has also demonstrated the large demand for, and wide acceptance of, such a system among the Medicare population. The overwhelming majority of our 145,000 Medicare members are very pleased with their health care system.

We will be happy to respond to any questions you may have.

IMC POLICY ON PRESCREENING AND ENROLLMENT

1. IMC's standard Affiliated Provider Agreement requires the Affiliated Provider to notify all existing patients that the center has become an IMC affiliate and to assist IMC in enrolling interested Medicare beneficiaries. The contract also includes a non-discrimination provision which specifically prohibits prescreening on the basis of health status. In addition, the Affiliated Provider Agreement requires providers to abide by HCFA regulations and IMC policy and procedures. (Attachment A)

2. The IMC Affiliated Provider Operations Manual contains a number of provisions addressing these issues. The section outlining significant features of IMC's Medicare contract provides that there shall be no health screening for any enrollee.

The section on Disenrollment Procedures advises the Affiliated Providers that under no circumstances will a member be disenrolled against his or her will or for a medical condition. It also warns that any attempt to force a member to revert to Medicare will result in termination of the Affiliated Provider's contract. (Attachment B)

3. On April 18, 1985 a letter was sent to all Affiliated Providers under the signature of Dr. Angel Alvarez. That letter transmitted IMC's formal policy statement related to the rights of Medicare beneficiaries. The cover letter emphasized the IMC policy prohibiting health screening prior to enrollment and involuntary disenrollment. The formal policy statement sets forth a number of contractual obligations under IMC's contract with HCFA, emphasizing the prohibitions on prescreening and involuntary disenrollment. The statement also sets forth procedures intended to assure compliance with these requirements. (Attachment C) Those procedures include:

a. Posting in a conspicuous place in the center the "Gold Plus Plan Member's Bill of Rights";

b. Easy accessibility of blank membership application forms at the centers;

c. Advising Medicare beneficiaries to mail the membership application forms directly to IMC rather than turning them into the center;

d. Submission of application forms by the center only if the Medicare beneficiary requires assistance in completing the application;

e. Submission of application forms daily by the centers and verification of the date of application by IMC's membership services department;

f. Suspected violations of the no prescreening policy are to be referred to the Member Relations Department for investigation;

g. In the cases involving verified violations, IMC is to offer the beneficiary membership in the Gold Plus Plan and if the beneficiary chooses not to enroll in the offending center, the cost incurred by the center which the applicant chooses will be charged to the offending center. IMC will also consider any other actions or penalties as warranted.

4. The IMC Gold Plus Plan Patient's Bill of Rights which, as discussed above, is to be posted in each Affiliated Provider location, clearly prohibits prescreening of Medicare applications and provides that disenrollment from IMC is purely voluntary.

MONITORING AND ENFORCEMENT PROCEDURES

1. The Member Relations Department conducts an exit interview on each member that disenrolls from IMC. These interviews are performed by telephone and include a specific question addressing whether the disenrollment is voluntary. When an involuntary disenrollment is identified through this mechanism, copies of the disenrollment forms, exit interview and any additional documentation are given to the Member Relations Department for further investigation.

2. Another procedure that is useful in monitoring prescreening is related to the contractual requirement that the Provider notify all its patients of its new status as an IMC Affiliated Provider. As this provision is currently implemented, the new Affiliated Provider supplies a list of patients to IMC's Medicare Marketing staff and Medicare Marketing prepares a letter, on the provider's stationery, to each patient and arranges for group or individual presentations of the IMC plan.

3. Although the Quality Assurance reviews are not specifically designed to identify prescreening on the part of Affiliated Providers, there are some questions in the first phase of the Quality Assurance study which would bring to the attention of an experience reviewer the possibility that prescreening is occurring. In those instances where potential prescreening activities have been identified, further studies are conducted.

other utilization. In all other cases, if you have good reason not to use a Contracting Hospital or other Provider listed on Schedule 2.4, you must notify IMC five (5) business days in advance of the proposed hospitalization or other utilization giving your reasons and naming the provider you propose to use. You agree to cooperate with IMC in selecting another hospital or provider and you understand that such other hospital or provider must agree to be bound by Governmental Regulations and IMC policies and procedures to hold the patient harmless for any payment for Covered Services.

ARTICLE III

Your Functions and Duties as an Affiliated Provider

3.1 **You Provide Covered Services.** You shall provide to, and be financially responsible for all Covered Services provided to Members selecting you as their affiliated provider. You shall be financially responsible for all medically necessary Covered Services provided to such Members by others even without your approval where such services are emergency medical services or urgently needed services (as defined by IMC for each class of Members) or services to which the Member was entitled as determined under the Grievance Procedure. These services shall be paid for in accordance with Article IV of this Contract. You agree that IMC shall have the right to add to or delete from the list of Covered Services to accommodate changes in Regulations, Master Group Agreements, Individual Agreements, or for other good reasons. Such changes will not relieve you of your obligation to provide *all* Covered Services for which you will be paid as provided in Article IV.

3.2 **You Accept Sole Payment From IMC.** You shall accept as full and sole payment for all your obligations and duties hereunder only the payments from IMC described in Article IV of this Contract. You agree to provide all Covered Services to Members without cost to the Member (except for Co-payments authorized by IMC which are to be distributed as described in Article VIII). You shall not seek any payments for Covered Services from a Member under any circumstances.

3.3 **You Must Notify Your Patients.** You shall notify all of your existing patients that you have become an affiliated provider with IMC and cooperate with IMC in providing your patients with information about IMC and the "Gold Plus Plan". You shall help enroll all such patients who wish to enroll in the Gold Plus Plan. You may continue to treat your existing patients who do not wish to enroll in the "Gold Plus Plan" as part of your private practice. Enrollment and disenrollment are absolutely voluntary and you shall not pursuade or coerce any Medicare beneficiary for any reason.

3.4 **No Discrimination.** You shall not discriminate against any Member or potential Member for any reason including, but not limited to, age, race, creed, national origin, medical history or health status. You shall not perform any pre-screening prior to enrollment.

3.5 **Monthly Listing of Members.** IMC will provide you with a monthly listing of all Members who have selected you as their affiliated provider. You agree that you are fully responsible for providing Covered Services to all of the Members on such list. You also understand that the Covered Services are listed on Schedule 3.5 of this Contract but that they may be added to or subtracted from periodically by IMC and you agree to provide any services added to the Schedule. You also understand that you are required to utilize the IMC Network in providing these Covered Services as described in Article II of this Contract.

3.6 **24-Hour Answering Service.** You agree to maintain a 24-hour telephone answering service available for Members in order to facilitate providing health care to such Members including emergency medical services.

3.7 **Certified Public Accountants.** You agree to engage a certified public accountant to certify the financial reports required to be submitted by you to IMC.

3.8 **You Must Abide by IMC Procedures.** You agree to abide by the procedures, practices and policies at any time established by IMC in connection with delivery of health care services, financial and accounting practices, informational reporting, quality assurance, utilization control, peer review, membership policies and procedures, and related matters.

3.9 **Agreement of Your Sub-Network to Abide by Procedures.** You agree to obtain from each Provider who will be a part of your Sub-Network a written acknowledgment that such Provider will comply with the terms and conditions of this Contract relating to the health care to be provided to a Member, with the Regulations (specifically including §1861 and §1876(b)(1)(b) of the Social Security Act, as amended, with respect to Medicare Members), with the quality assurance, utilization control, and peer review procedures of IMC in effect at any time, and with all other rules or regulations by which IMC is bound in providing health care to members.

DADE COUNTY
[illegible] IMC-HMO [illegible]
[illegible] Medical Center
[illegible] & Associates, P.A.
[illegible] Medical Associates
Biscayne Medical Center
Comprehensive Health Care [illegible]
Camilo [illegible], M.D.
Dr. I. [illegible] & Dr. J. Torres
[illegible] D.O.
IMC-HMO [illegible] Little River
IMC-HMO Miami 1
IMC-HMO North Dade
IMC-HMO Westchester
Medical Health Centers, Inc.
Medicorp, Inc.
Midway Medical Center
Norwood Medical Center
Physicians Center
Suburban Medical Center
[illegible] Medical Center
IMC-HMO Miami Beach
Jefferson Plaza Medical Center
Medical Center at Sunny Isles
[illegible] Shores Medical Center
[illegible] Medical Center
Miami Shores HMO
Omni Medical Center
Physicians Medical Center
Albert [illegible] D.O., P.A.
Skylake Medical Center

BROWARD COUNTY
[illegible] Creek Medical Service Ctr.
[illegible] Medical Center
Sunrise Medical Center
[illegible] Medical Center
[illegible] Medical Centers of Brwd.
[illegible] Center at Century Plaza
North Federal Medical Center
Doctors Health Center
Doctors Medical Center
[illegible] Lauderdale Medical Center
[illegible] Practice Medical Center
Lauderdale Medical Center
[illegible] General Practice, P.A.
Hallandale Medical Pavilion
[illegible] Medical Centers of Brwd.
Cooper Medical Center
IMC-HMO Hollywood
[illegible] Family Health Centers
[illegible] Medical Service Center
Dr. Harry [illegible] & Associates
Palm Medical Center
Medical Pavilion
Plantation Medical Center
Family Health Center
[illegible] Plaza Medical Center
Pompano Medical Center
[illegible] Medical Centers of Brwd.
[illegible] Medical Center
Community Medical Center
Pine Island Medical Center
[illegible] Medical Center, Inc.

ALM BEACH COUNTY
[illegible] Walk-in Medical Center
[illegible] Center at W. Boca Raton
Physicians Center, Inc.
[illegible] Office, Inc. IMC-HMO
[illegible] Family Medicine Center
[illegible] Medical Group, Inc.
[illegible] Point Medical Center
Seniors Health Center
[illegible] County Medical Center
Family Medical Centers
GRV Medical Center
[illegible] Inclusive Plan of Fla.
[illegible] S. Johnson, M.D., P.A.

OROUGH COUNTY
Brandon Family Care
[illegible] Family Practice
[illegible] Surgical Walk-in Center
[illegible] City Medical Center
Riverview Center
[illegible] Care of Sun City, Inc.
[illegible] Medical Facility
[illegible] Park Medical Center
[illegible], M.D.
[illegible] Center
[illegible] Medical Center
[illegible] Practice Center
[illegible] Medical Center
[illegible] Associates 1 & 2
[illegible] Medical Center

PASCO COUNTY
[illegible] Medical Center
[illegible] Medical Center
[illegible] Medical Center
[illegible] Medical Center

ELLAS COUNTY
[illegible] Medical Care
[illegible] Primary Center
Medical Center, Inc.
[illegible] Care Safety Harbor
[illegible] Medical Center
Medical One
[illegible] Medical
[illegible] Medical Center
[illegible] One-Medical 65

International Medical Centers - HMO
Executive Offices 1505 N.W. 167 Street • Miami, Florida 33169 • (305) 621-4222

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

April 18, 1985

Dear Affiliated Provider:

We are pleased to enclose, for your information and compliance, a copy of the policies and procedures approved by the IMC Executive Committee, effective immediately, for the purposes of

1) strengthening understanding of the rights of Medicare beneficiaries who apply for enrollment in the IMC Gold Plus Plan, and

2) assuring compliance with IMC's contractual obligations with the Health Care Financing Administration.

Please advise your professional and administrative staffs that any violation of these policies and procedures will be viewed as a critical failure on your part to comply with our contract with you and may lead to its termination. Strong emphasis must be placed on the following policies:

> No pre-existing condition (with the only exception of chronic renal disease requiring dialysis and related services) precludes Medicare beneficiaries from enrolling in the Gold Plus Plan. Therefore, there shall be no health screening for any enrollee or applicant for enrollment for the benefits offered and approved by HCFA.
>
> Disenrollment from the Gold Plus Plan is absolutely voluntary and no Medicare beneficiary shall be asked, requested, persuaded or coerced to disenroll for any reason.

You will be provided with a poster outlining the rights of individuals prior to enrolling and after becoming members of the IMC Gold Plus Plan. This poster must be prominently and permanently displayed in a public area of your facility.

We plan to conduct an immediate and exhaustive investigation of any suspected violation of these policies, for appropriate action.

We will greatly appreciate your cooperation in complying with these policies and procedures.

Should you have any question(s), please contact Mr. Alan M. Gilbert, Vice President Operations Support, at 623-2458.

Sincerely,

Angel A. Alvarez
Senior Vice President
Corporate Policies and
Membership Research

AAA/JJT/ef

cc: Miguel Recarrey, Jr.
Gerard W. Frawley
Senior Vice Presidents
Juan Jose Tarajano
Alan M. Gilbert

International Medical Centers

POLICY STATEMENT

FUNCTIONAL AREA: Health Plan Operations

DEPARTMENT: Membership Services

RESPONSIBLE OFFICER: Robert L. Harris, Senior Vice President

SUBJECT: **Rights of Medicare Beneficiaries**

PURPOSE:

1. To strengthen understanding of the rights of Medicare beneficiaries wh apply for enrollment in the IMC Gold Plus Plan.
2. To assure compliance with IMC's contractual obligations with the Healt Care Financing Administration (HCFA).

POLICY STATEMENT:

Medicare beneficiaries who are entitled to benefits under both Part A and Pa B, or Part B only, of Title XVIII of the Social Security Act, and reside in th IMC's service area, may enroll in the IMC Gold Plus Plan, with the only excep tion of those who have chronic renal disease and are receiving dialysis an related services at the time they apply for membership in the Plan.

No pre-existing condition, with the only exception described above, preclude a Medicare beneficiary from enrolling in the Gold Plus Plan. Therefore, ther shall not be any health screening for any enrollee for the benefits offered an approved by HCFA for the IMC Gold Plus Plan.

Medicare beneficiaries enrolled in the Gold Plus Plan may voluntarily dis enroll at any time for any reason.

No Medicare beneficiary enrolled in the Gold Plus Plan shall be requested persuaded or coerced to disenroll for any reason.

There shall be assurance that the IMC membership's health care needs are met in an appropriate, timely fashion.

Health care services to all IMC members shall be delivered at the highes possible level of professional quality and responsiveness to the individua needs, thus assuring the acceptability of services rendered to plan members.

The rights and responsibilities of IMC members shall be fully and clearly explained to every applicant for enrollment.

PROCEDURES:

1. A poster outlining "Gold Plus Plan Members' Bill of Rights". (copy enclosed) shall be placed in a public area of all IMC wholly owned and affiliated medical centers.
2. Blank membership application forms shall be made easily accessible to potential members in a public place within every center, preferably under the poster with the Bill of Rights described above.
3. Medicare beneficiaries who complete an application for enrollment shall be advised to mail it directly to the IMC Membership Department rather than returning it to the center.

THIS MANUAL IS THE PROPERTY OF INTERNATIONAL MEDICAL CENTERS AND MAY BE USED ONLY IN A MANNER AND BY PERSONS APPROVED BY THE COMPANY

4. If a Medicare beneficiary requires assistance in completing the application form and the statement of understanding, he/she may do so at the center and have the center forward the form on his/her behalf to the IMC Membership Services Department.

5. The centers will submit daily to the Membership Services Department all membership applications they receive or are requested to submit on behalf of applicants. The Membership Services Department shall verify the date of the application versus the date of receipt and investigate any unusual or repeated delays.

6. Any suspected violation of the no pre-screening policy shall be referred to the Department of Member Relations for an immediate, exhaustive investigation. The results of this investigation shall be notified to the Senior Vice President for Health Plan Operation, with copies to the Senior Vice President for Corporate Development and the Senior Vice President for Medical Affairs, for appropriate decision.

7. If it is verified that a Medicare beneficiary is denied enrollment or persuaded not to enroll in violation of policies, IMC will offer him/her membership in the IMC Gold Plus Plan. Should applicant decide to join the plan but not to choose the offending center, the cost incurred by the center of the applicant's preference for health care services provided to this member shall be charged to the offending center and IMC will consider other actions or penalties, as warranted.

International Medical Centers HMO

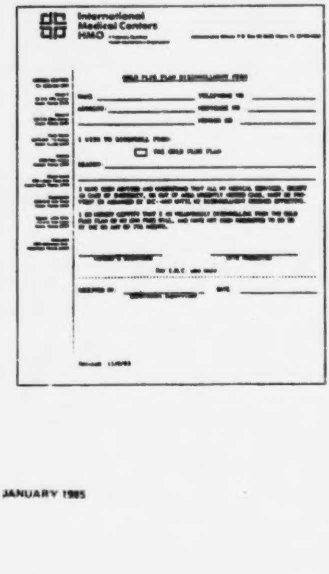
Subject:

Disenrollment Procedures— Gold Plus Medicare

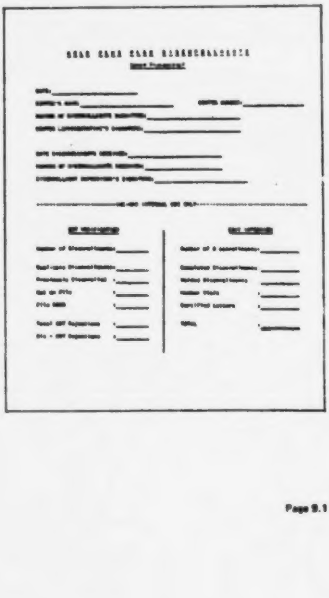
Any HMO member wishing to terminate his/her membership with IMC can do so by completing a disenrollment form. All disenrollment forms must be signed by the patient. Name and Medicare number should appear as the information reflected on the membership printout roster. The white and yellow copies of the disenrollment form are batched and submitted to Membership Services. (Please refer to sample Gold Plus Plan Disenrollment Batch Transmittal. The top portion of this form needs to be completed including date, center name, center number, number of disenrollments submitted, and center representative's signature.) The pink copy of the disenrollment form is then given to the patient. You must inform the patient that he/she will receive a letter of confirmation with the effective date of his/her disenrollment from our Membership Services Department when the disenrollment has been processed.

All disenrollment requests received within a month's period will be effective the first of the following month, i.e., disenrollments received the first to the thirty-first of August will be effective September first. However, since the monthly deletions (disenrollments) must be submitted to the Health Care Financing Administration by the twenty-fifth of the month all those disenrollments received by Membership Services by the twentieth of the month at 5:00 p.m. will be processed before the first.

Even though all disenrollments received during the entire month will be effective the first, those received from the twenty-first to the thirtieth or thirty-first will be submitted with the following month's deletions and made retroactive to the first.



International Medical Centers HMO



A monthly deletion roster will continue to reflect those disenrollments received by the twentieth of the month. In addition, an updated deletion roster will be provided by the tenth of the following month reflecting the disenrollments received from the twenty-first to the thirtieth or thirty-first of the month.

Financial adjustments on disenrollments received after the twentieth of the month will then be done by the Affiliated Providers Finance Department.

It is suggested that the centers keep copies of the disenrollments along with a log so that verification can be done by center personnel (illustrated below). Please be aware that IMC will conduct an exit interview on all disenrollments as per our obligation to HCFA. Our Membership Services Department will conduct these interviews as part of disenrollment procedures. Also, be advised that under no circumstances will a member be disenrolled against his/her will or for a medical condition.

Any attempt to force the member to revert back to Medicare is in violation of HCFA guidelines. This action is also in violation of IMC-HMO's contract with the Affiliated Provider. Any deviation from this policy will cause a termination of Affiliated Provider's contract.

By the same token, a member can disenroll at any time for any reason he/she wishes.

There are no provisions against someone who wishes to re-enroll with IMC after he/she has disenrolled.

Someone moving out of IMC service area will automatically have a mandatory disenrollment.

DISENROLLMENT LOG

DATE OF DISENROLLMENT	MEMBERS NAME	ID NUMBER	MEDICARE NUMBER	REASON WHY	DATE SENT IN	IS THIS A RETROACTIVE DISENROLLMENT (AFTER THE 20th OF THE MONTH)	NEXT PRINTOUT (YES/NO)

International
Medical Centers
HMO

Subject:

Significant Features of IMC-HMO Contractual Obligations

(Related to the Medicare Prospective Capitation Demonstration Program)

- IMC-HMO (referred to as the Health Plan [HP]) has contracted with the **Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services**, the provision of all services covered under **Part A and B, and Part B only**, to its Medicare enrollees, either directly or through effective arrangements with other providers of services.
- For the purpose of this contract, the term "**provider of services**" means an institution, facility or agency so designated in listings furnished by the HCFA as a participating provider of services, under Title XVIII, of the Social Security Act.
- The term "**Medicare Enrollee**" means an eligible individual, who is entitled to benefits under both Part A and Part B, or Part B only, of Title XVIII of the Act, who is enrolled in the Health Plan pursuant to the demonstration grant and this contract.
- "**Dual eligible enrollees.**" As requested by the Deputy Assistant Secretary for Medicaid, please explain in detail to every applicant for enrollment and current enrollees in the **Gold Plus Plan**, who are also entitled to Medicaid benefits, that:
    1) Medicaid pays to Medicare the premium for Medical Insurance on behalf of dual eligible beneficiaries, to purchase Medicare coverage.
    2) Medicaid will not make any co-insurance or deductible payments, for dual eligibles enrolled in the **Gold Plus Plan**.
    3) Members eligible for Part B only and Medicaid, will not be charged a co-payment for prescribed drugs. And they *cannot* use the Medicaid monthly allowance for medication.
    4) Members with Part B only/Medicaid, are subject to the "**lock-in**" provision of the **Gold Plus Plan**; that is, even though they are entitled to hospitalization and nursing home care under Medicaid, these services have to be provided or arranged and authorized by IMC-HMO. Otherwise, neither IMC-HMO nor Medicare is obligated to pay for any Part B services received by Part B only enrollees outside the IMC-HMO system, except in emergencies anywhere or urgently needed medical care outside the service area (Dade and Broward counties). The State of Florida has also indicated that it has no Medicaid liability for unauthorized expenditures; that is, expenditures requested for services not authorized by IMC, except for emergencies or urgently needed medical care outside the service area, but the enrollee should notify IMC within 24 hours of receiving such care.
    5) To assist members and providers, Medicaid will indicate on the Medicaid identification card that the recipient is enrolled in the IMC-HMO Medicare Demonstration Project. Since IMC and the telephone number of our Admission and Insurance Verification Office will be printed on the Medicaid ID card, the provider can call if the beneficiary was not referred by IMC.

We are also requesting that members with Part B only and Part B only/Medicaid, be advised of the services to which they are entitled under the IMC-HMO **Gold Plus Plan**. A copy of the benefits included in the Plan is enclosed for reference, if needed. Remember, however, that the $3.00 co-payment for each prescription and refill ordered by the IMC-HMO medical staff will not be charged to members with **Part B only/Medicaid**.

- The "**service area**" at the inception of this contract shall be Dade and Broward Counties.
- There shall not be health screening for any enrollee for the benefits offered and approved for this demonstration.
- Nothing in this contractual agreement precludes the Health Plan from entering into subcontracts with other providers of health care services to enrollees. In the event of such a subcontract, the Health Plan remains responsible for the performance of all functions and duties specified in the contract with HCFA.
- The Health Plan shall comply with such regulations and general instructions as the Secretary of the U.S. Department of Health and Human Services (DHHS) or HCFA may, from time to time, prescribe with respect to HMOs for the administration of this contract.
- The Health Plan will provide additional supplemental benefits to its Medicare enrollees according to contract stipulations.
- The cost of dialysis and related services to CRD beneficiaries (those with end stage kidney disease), will be paid by Medicare intermediaries and carriers consistent with procedures described in general instructions, applicable to HMOs.
- The Health Plan shall adopt policies and procedures, to insure that the information contained in its records and obtained from HCFA, or from others in carrying out its functions and duties under this contract, shall be used by it and disclosed solely as provided in Section 1106 of the Act (42 USC 1306), the Freedom of Information Act (5 USC 552), the Privacy Act (5 USC 552a) and

the regulations prescribed under such Acts

- The subcontracted service provider is required to agree that the Secretary, HCFA and the Comptroller General of the United States (including their fully authorized representative), until the expiration of three (3) years after the terms of this contract, shall have access to and the right to examine any directly pertinent books, documents, papers and records of such subcontractors involving transactions related to the subcontract
- The Health Care Financing Administration shall have the right to inspect, or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract.
- The Health Plan shall maintain grievance and appeal procedures, in accordance with regulations and general instructions. Meaningful procedures for hearing and resolving grievances, will assure that grievances and complaints will be transmitted in a timely manner, to appropriate decision-making levels within the organization, which have the authority to take corrective action
- The Health Plan has agreed to comply with the Privacy Act of 1974, and the rules and regulations issued pursuant to the Act in the design, development and operation of any system of records on individuals, in order to accomplish an agency function when the contract specifically identifies:
  a. The specific system of records
  b. The work to be performed by the Health Plan in terms of any one or combination of the following
    1) Design
    2) Development, or
    3) Operation

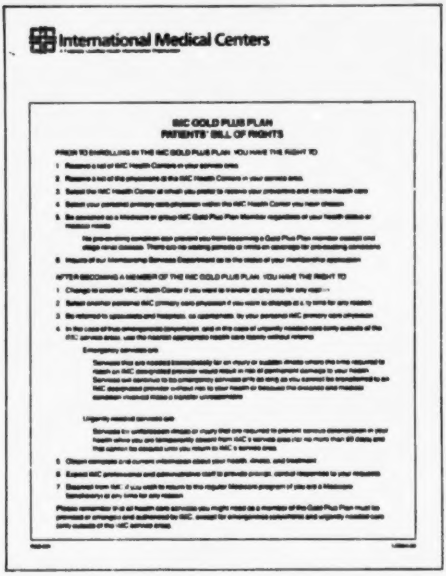
The solicitation notification contained in this contract, shall be included in every solicitation and resulting subcontract, and in every subcontract awarded without solicitation, when the statement of work in the proposed subcontract requires the design, development, or operation of a system of records on individuals to accomplish an agency function

This clause shall be included in all subcontracts awarded pursuant to this contract, which require the design, development, or operation of a system of records

"**Record**" means any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to ... medical history ... and that contains his name, or the identifying number, symbol or other identifying particular assigned to the individual, such as a finger or voice print or photograph

"**System of records**" on individuals, means a group of any records under the control of any agency, from which information is retrieved by the name of the individual, or by some identifying particular assigned to the individual

"**Operation of a system of records**" means performance of any of the activities associated with maintaining the system of records, including the collection, use and dissemination of records.



International Medical Centers

IMC GOLD PLUS PLAN
PATIENTS' BILL OF RIGHTS

PRIOR TO ENROLLING IN THE IMC GOLD PLUS PLAN, YOU HAVE THE RIGHT TO:

AFTER BECOMING A MEMBER OF THE IMC GOLD PLUS PLAN, YOU HAVE THE RIGHT TO:

DISTRIBUTION:

Miguel Recarey, Jr.
Juan A. Del Real, Esq.
Gerard W. Frawley
Stephen E. Cohen
Angel A. Alvarez
Julio A. Avello
Eddy F. Fernandez
Robert L. Harris
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Rene Diaz de Villegas
Leonard I. Weinstein
John J. Donnelly
Juan J. Tarajano
IMC Wholly Owned Medical Centers
Affiliated Medical Centers

	EFFECTIVE DATE April 2, 1985
APPROVAL Gerard W Frawley	DATE 4-8-85
ANNUAL REVIEW/REVISION	DATE
ANNUAL REVIEW/REVISION	DATE
ANNUAL REVIEW/REVISION	DATE
ANNUAL REVIEW/REVISION	DATE

IMC Gold Plus Plan℠

Miguel Recarey, Jr.
President

March 31, 1986

Dear Affiliated Provider:

As you may know, the federal government is currently investigating allegations of Medicare fraud against two medical centers in Broward County. A copy of a newspaper article referencing the investigation is attached. Since these centers are IMC Affiliated Providers, I am very concerned about the allegations and wish to take this opportunity to reaffirm IMC's commitment to full compliance with all federal rules and regulations.

In April 1985, IMC issued the attached policy statement addressing the rights of Medicare beneficiaries in relation to the IMC Gold Plus Plan. Please review this policy statement with particular attention to the enrollment and disenrollment provisions.

WITH THE EXCEPTION OF INDIVIDUALS WITH CHRONIC RENAL DISEASE, NO MEDICARE BENEFICIARY MAY BE DENIED ENROLLMENT IN IMC ON THE BASIS OF HIS OR HER HEALTH STATUS. ACCORDINGLY WE WISH TO EMPHASIZE ONCE AGAIN THAT AN AFFILIATED PROVIDER MUST NEVER ENGAGE IN HEALTH SCREENING OF IMC APPLICANTS. Under federal regulations, all applications for enrollment must be submitted to IMC on the date of application and must be processed by IMC in chronological order without regard to the health status of the applicant.

When a patient is referred to your center by IMC, or otherwise applies for enrollment, any services that are not medically required to be performed prior to the effective date of the individual's enrollment should be deferred until the patient's membership effective date. Of course, where a condition requires immediate medical attention, you are free to treat the patient on a fee-for-service basis until he or she becomes an IMC Gold Plus Plan member. Under no circumstances should you perform routine tests for the purpose of evaluating the individual's general health status prior to the effective date of enrollment. The only possible exception to this prohibition would be where the enrollment applicant is one of your pre-existing patients and, as part of the individual's normal course of treatment, periodic tests are due to be performed prior to the membership effective date. Even with respect to your pre-existing patients, however, any indication of a pattern of routine testing prior to enrollment will be treated as evidence of pre-screening.

With respect to disenrollment, Medicare beneficiaries may disenroll voluntarily from the Gold Plus Plan at any time for any reason. NO BENEFICIARY SHALL BE REQUESTED, PERSUADED OR COERCED TO DISENROLL ON THE BASIS OF HIS OR HER HEALTH STATUS. Federal regulations provide for involuntary disenrollment only under very limited circumstances and set forth a specific process that must be followed prior to any involuntary disenrollment. Therefore, Affiliated Providers should contact IMC's Network Operations Department before taking any action to involuntarily disenroll a Medicare beneficiary.

Your Affiliated Provider Agreement requires strict compliance with these requirements as well as other Medicare rules and regulations. You should also refer to the IMC Affiliated Provider Operations Manual for further guidance.

In light of recent allegations, IMC will be strengthening its monitoring procedures with respect to these issues. IMC will act quickly to terminate its Agreement with any Affiliated Provider found to be in violation of these requirements, and inform the Federal Government to that effect. We look forward to your cooperation.

Sincerely,

Miguel Recarey, Jr.
President

MR:ms
Enclosures

FORT LAUDERDALE News/Sun-Sentinel, Saturday, March 22, 1986 3B

U.S. investigating Medicare practices at 2 Broward HMOs

By Joseph Cosco
Staff Writer

The U.S. Department of Health and Human Services and the FBI are investigating two Broward County health maintenance organization clinics thought to be involved in a scheme to defraud the Medicare program.

According to federal court documents, the two HMOs are Doctor's Gold Plus Center I at 1777 S. Andrews Ave., Fort Lauderdale, and Doctor's Gold Plus Center II at 4931 S. State Road 7, Davie. The two clinics are independent subcontractors affiliated with International Medical Centers.

Dr. Christino Enriquez, a practicing physician and owner/operator of the two clinics, and Elaine Herold, the administrator of Center I, are the targets of the investigation, according to an affidavit filed in U.S. District Court in Miami.

Officials of International Medical Centers were in contact with the HHS Office of Inspector General and the U.S. Attorney's Office and were told the company was not a target of the investigation, said spokeswoman Barbara Ferreiro. "We are offering our fullest cooperation in the investigation of these two centers," she said. "We have no ownership interest in these two centers."

The alleged scheme "was to defraud the federally funded Medicare program by prescreening patients prior to enrollment in order to generate additional income for the centers and to screen out those patients who were seriously ill and would be costly for the centers to treat," according to the affidavit filed by a special agent with the HHS Office of Inspector General.

No formal charges have been filed in the case, but the investigation is continuing in cooperation with the U.S. Attorney's Office, said FBI spokesman Paul Miller in Miami. "Medicare fraud is a problem we're trying to resolve very quickly," he said.

U.S. Magistrate Patricia Kyle issued search warrants for both centers, and searches were conducted on Wednesday. Agents seized patient files, enrollment forms, internal memos, appointment books, Medicare insurance claims, financial records, personnel records, and other documents.

According to the affidavit, HHS special agent Leon Weinstein was tipped off to the alleged scheme by a supervisor at Center II and an employee at Center I, identified in the court documents only as Source I and Source II.

The affidavit claims that the two clinics violated the law by refusing to enroll some patients who qualified for the plan and by billing Medicare for routine physical examinations that were purported to be "free pre-HMO physical exams."

Medicare does not pay for physicals that are not related to the diagnosis or treatment of specific ailments.

"After the examination Source I stated that she prepared Medicare claim forms, stating the diagnosis that was indicated by the doctor," according to the affidavit. "If no diagnosis was indicated, pursuant to the instructions of Ms. Elaine Herold, Source I would make one up in order to get Medicare to make the payment. These Medicare forms were all stamped with Dr. Christino Enriquez's name prior to mailing to Florida Blue Shield for payment."

The exams also were used to prevent the enrollment of seriously ill, and therefore potentially costly, HMO patients in violation of the clinics' contract with HHS, according to the affidavit.

When International Medical Centers periodically sent representatives to check on the clinics' paperwork, Herold told Source I to lie to them, according to the affidavit.

STATEMENT OF ROBERT WILSON

Mr. Wilson. Yes, Congressman. Thank you again, for having an opportunity to be present here and to address the issues that you have raised in the survey that you have mailed out to all the members in your area.

My name is Robert Wilson. I am the general manager of the Palm Beach Regional Office for the Av-Med Health Plan.

The Av-Med Health Plan is one of the oldest and largest in Florida, but we are different from the IMC model, in that we are an independent practice association model. And I think we need to explain briefly what this model is, and I think I can do that by just saying that an independent practice association model is one which contracts with individual physicians and individual hospitals to provide the medical services to our enrolled members in their offices as they would any other private patient. And that differs from a group model or a staff model in which there are centralized facilities for which there are physicians who are employed by the HMO organization to provide that service.

We became involved in the Medicare participation in November 1982, and last year our membership topped off at 12,000 members per month. This includes the three counties of southeast Florida—Dade, Broward, and Palm Beach—and Tampa Bay area. At the present time, that membership has decreased, because we have discontinued our membership program in the Tampa Bay area, and at the present time we are not marketing our Medicare Program in Palm Beach County. We do have, though, approximately 200 Medicare members in our program in Palm Beach County.

The survey that you sent out to your constituents identified four major problems: (1) not being able to care for seriously ill patients; (2) the exaggerated claim on services and benefits; (3) inefficient reimbursement procedures; and (4) inadequate referrals for hospitals. I would like to briefly address those particular issues.

In terms of exaggerated claims on services and benefits, we do have a very extensive marketing program, and I would like to submit into the record examples of the Medicare information enrollment form we send out to people that inquire about our services.

Mr. Mica. Without objection, that will be received.

Mr. Wilson. Also, this information, I believe, is developed in conjunction with the region IV office of HCFA and does have, I believe, the approval of them before it is used in marketing.

We have a very definitive enrollment process in which if a member calls up, they are identified as to whether or not they can participate in a particular plan. We then send out information to them. When the application is received back to us, then another telephone call is made to that member, and all the information is gone over with them and the enrollment application is gone over with them, so that the member himself, or herself, is fully aware of what type of a program that they are getting into.

We do also have some disenrollments, and we have a particular problem in regard to disenrollment, which maybe you can assist us with. And this is in regard to if a member enrolled is a member of our HMO, and they want to enroll in another HMO, say on March

10, the new HMO then requests a retroactive enrollment back to March 1; however, our HMO is not notified of that until about the middle of April.

So, during that 6-month period of time, we have provided services to the member, perhaps the new HMO has provided services to the member, and in the meantime then, when we get notification that they are no longer a member of our group, we have to go back and tell the providers that we have to deny payment for those claims, and this has created quite a problem with us.

We have a very extensive provider network in Dade, Broward, and Palm Beach County. As I mentioned earlier, as an independent practice association model, we contract individual physicians for services. At the present time we have over 2,000 physicians contracted in our program in the three counties.

About one-third of these physicians are what we would consider primary-care doctors, and two-thirds are specialists, and they cover most of the disciplines.

In our particular program, when a member enrolls in the Av-Med Health Plan, they must select a primary-care physician, and that physician then becomes responsible for managing and directing all the medical care that that member needs. It is extremely important that the member should know that whenever they need medical care, that they must go to their primary-care doctor that they have selected.

We have a very extensive credentialing process that we engage in when a physician wants to participate in our program. We also have a very extensive hospital network. We have over 40 hospitals in the three counties that we have under contract; some of these are full-service hospitals, and others are specialty-care hospitals.

In additon to the provider hospital network, we have a very extensive ancillary-services network providing ambulance, ambulatory surgery, cardiac diagnostic home/health services, nursing homes, and whatever type of medical care that the member might need. We do arrange for whatever care is necessary, and we do this in conjunction with the patient's or the member's primary-care physician.

Claims processing was another major problem that was identified in your survey, and I can truthfully say that if we get a clean claim-a claim that is completely filled out, that has no problem with it-we can pay that claim within 4 weeks.

Now, the problem is that in most cases the major problem is that there is missing or wrong information on the claim form that we receive. And if that happens, then we must go back to the provider of care and gather the additional information, and this delays the payment of that claim.

Another big problem we have is that we receive claims that are not appropriate to our services. For instance, if a member is involved in an automobile accident, Av-Med is not responsible for the payment of that claim, the automobile insurance company is, and yet we receive the claim form from the provider of care, and then we have to go back and go through a process of identifying who was the primary payer and try to resolve the problem that way. And in that sense, it does take more time to pay the claims.

We also have a very extensive complaint and grievance procedure, and I have brought copies of that which, again, I would like to submit for the record.

Mr. MICA. Without objection.

[The material submitted by Mr. Wilson follows:]

COMPLAINTS

Policy

The purpose of this policy is to set guidelines for resolving complaints filed by members or providers of the AV-MED Health Plan. A complaint is any oral or written expression of concern, dissatisfaction or protest regarding an AV-MED Health Plan or IPA service or procedure, other than claim disputes, whether medical or non-medical in nature, when the member or provider requests the initiation of this formal procedure.

Procedure

I. Member Complaints

A member may voice a complaint via a telephone call or submit it in writing to the Consumer Relations Department. If the complaint is by telephone, the call will be routed to the Consumer Relations Department for discussion of the incident with the member. If the complaint is in writing, follow-up by the Consumer Relations coordinator will consist of calling the member to get a detailed account of the incident in question.

The Consumer Relations coordinator, after obtaining details and clarification from the Plan members, and gathering all pertinent information or documents, will contact all personnel involved for resolution of the complaint. The Consumer Relations coordinator will contact the member and discuss the proposed solution within 20 days of receipt of the complaint.

If the solution is agreed to by the member, a copy of the complaint and solution with all follow-up information will be sent to the Director of Administration of AV-MED Health Plan for review, along with any recommendations for procedural changes as a result of the complaint.

In the event the complaint cannot be resolved by this process, all follow-up information and suggestions for resolution will be sent to the Director Administration who will then review all information and take steps deemed necessary to reach a solution with which the Plan member and AV-MED Health Plan are satisfied within 30 days of receipt of complaint by the Consumer Relations coordinator. A copy of the solution will be sent to the Plan member and the Consumer Relations Department.

II. Provider Complaints

An AV-MED provider may submit a complaint to the Consumer Relations Department. The complaint will be reviewed by the Consumer Relations coordinator. Any pertinent information will be gathered and the complaint will be routed to the Medical Director for review. The Medical Director or his designee will contact all individuals involved for resolution of the complaint. If the solution is agreed to by the individuals involved the complaint will be returned to the Consumer Relations Department. A copy of the complaint and resolution with all follow-up information will be sent to the Director of Administration for review along with any recommendations for changes as a result of the complaint.

In the event the complaint cannot be resolved by the Medical Director, all follow-up information and suggestions for resolution will be sent to the Director of Administration who will then review all information and take steps deemed necessary to reach an amiable solution within 30 days of receipt of the complaint by the Consumer Relations Department.

GRIEVANCES

Policy

A grievance is any complaint that cannot be resolved within the complaint system to the members or providers satisfaction.

Procedure

The member or provider has the option to appeal any unresolved complaint to the grievance process. This appeal must be received in writing by the AV-MED Health Plan within one month (30 days) of the final disposition or action taken on the original complaint by the Director of Administration of AV-MED Health Plan.

After a written receipt of the appeal, the complaint will formally be considered a grievance, will then enter the grievance procedure and be routed to the Director of Administration for presentation before the Grievance Committee of AV-MED Health Plan and National Medical Management, Inc. This committee, a policy-making body, is in the position to recommend modifications in AV-MED Health Plan operations to avoid member and provider grievances in the future.

The parties involved shall receive written acknowledgement of receipt of said grievance. Prompt research and further evaluation of the problem shall then begin. Once all research has been completed, a hearing date will be scheduled.

The Grievance Committee shall have authority to enlist the services of a legal counsel, if it is deemed necessary. After all due consideration, the Grievance Committee shall take action on the Grievance, with written notification of said outcome sent to all parties concerned within 30 days of receipt of the grievance.

The decision of the Grievance Committee is final and reflects the decision of AV-MED Health Plan and National Medical Management. If any party (other than an AV-MED Medicare membr) is not satisfied with the decision of the Grievance Committee, they may pursue normal remedies of laws at their own financial liability.

Medicare Appeals Process

Policy

The purpose of this policy is to set guidelines for the appeal process (available) to AV-MED Medicare members in accordance with the provisions of 42 CFR 417.600-638. This process is for claims or disputes over one hundred ($100) dollars.

Procedure

In the event an AV-MED Medicare member is not satisfied with a decision made by the Grievance Committee, they are entitled to have the (case file) reviewed by the Department of Health and Human Services.

The member will be notified in writing that they have the right to request this review within 60 days of the date of notificationby AV-MED of their decision. The member will be instructed to send their request to the following address:

Chief, Reconsideration Branch
P.O. Box 770
Baltimore, Maryland 21203

Once AV-MED is notified of the request for this review, a copy of the entire (case file) and all documents with which AV-MED based its decision will be forwarded to the Department of HHS. Once the Department of HHS has reviewed the file, they will notify AV-MED and the member of their decision.

This decision will be final and AV-MED will comply with any recommendations or directives given by HHS on the disposition of the case.

Mr. **Wilson**. In summary, I think I would like to mention that a health maintenance organization, while not a new concept in the United States, is new and different to most people. It is an organized system which attempts to provide the level of health care needed by the member in a cost-efficient and a cost-effective manner; however, as we have seen, there is a lot of misunderstanding about how a health maintenance organization works, and it is very difficult for people to break old habits that they have had for many, many years.

I think another major problem is that there are different levels of expectations that have arisen, both by members and the providers, and I think that there is a need for an educational program about HMO's by different organizations, and I would like to commend the local chapter of the American Association of Retired Persons that recently put on a series of seminars in that regard, and I think that was most helpful.

Again, my thanks for allowing us to make a presentation, and any questions you have, I will be glad to answer.

Mr. **Mica**. Thank you, Mr. Wilson.

Mr. **Mica**. Dr. Sanders, let us get right into it quickly.

Can you first tell me, say, 2 years ago or 4 years ago, when you were at, say, 25,000 or 50,000 patients, how many doctors per patient you had with IMC?

Dr. **Sanders**. Well, we had—by Federal regulation, one has to have a specific ratio of primary care physicans to the number of Medicare enrollees, and that percentage is 0.875 primary care physicians per 1,000 Medicare enrollees, and that ratio is less, it is probably 1 to about 2,000 for commercial enrollees.

There is not a question of "How many do you have?" You have to have—in order to be in compliance, one has to have that type of ratio.

Mr. **Mica**. That is minimum compliance.

Mr. Wilson, do you meet minimum standards, or do you go above it?

Mr. **Wilson**. In what respect, sir?

Mr. **Mica**. Doctors per number of patients, enrollees?

Mr. **Wilson**. I do not know how to answer that, Congressman, because I am not familiar with——

Mr. **Mica** Do you know what I am getting——

Mr. **Wilson**. Yes, I am.

Mr. **Mica**. Here is—I have to tell you very frankly, when we called these hearings, my quick assessment was, "We're getting a lot of complaints; IMC is growing very rapidly, that's natural, they're probably growing so fast that they haven't put on enough doctors or expanded facilities."

What I am hearing this morning is far greater concerns than that, but that was the initial concern that I had, that you just do not have enough for the size of population. You are saying that you have always maintained the same ratio?

Dr. **Sanders**. Oh, yes; absolutely.

Mr. **Mica**. And you think it is adequate?

Dr. **Sanders**. You made the point that we kept the minimum ratio. I was just responding to the question of, "What is the Federal regulation?" We exceed the minimal ratio, but at the very minimum. We cannot go below that, and if we did, we would be in noncompliance, and I would welcome, you know, any external audit to determine whether or not we have adequate primary care and subspecialty care for the enrollee population.

Mr. **Mica**. OK. Well, let me just get to the basic question then. Why this outrageous number of new complaints in the last 6 or 8 months? We have had a large, large increase. As you know, our office has been sending them on to your office. We have had to go—instead of the regional office, we have had to go directly to HCFA in Atlanta.

One big complaint is that people are getting dunning notices; that their bills are not being paid and so on. What, in summary, is your explanation for all of the negative comments that we are getting?

Dr. **Sanders**. Well, I think in my statement, I did allude to the fact that we have also—we have paralleled the complaints that you have seen and we have noticed an increase in complaints, particularly relative to the claims-payment situation.

I would appreciate, with the Congressman's indulgence, if I could defer to Mr. Steve Cohen, who is our chief financial officer, who might elaborate a little bit on why we had the claims-payment problems, and what we have done already to try and effect the change.

Mr. **Mica**. I do not mind that. Please identify yourself for the record.

And also, while he is coming up, you mentioned you were putting a new system in effect that would stop a great number of these complaints. What is the system, and when will it be effective, how soon?

Mr. **Cohen**. We are hoping to have it on stream—we are actually—it is partially on stream now; we are expecting to have it fully operational by June 1.

Mr. **Mica**. And your name again is?

Mr. **Cohen**. Stephen Cohen.

Mr. **Mica**. Go ahead, Mr. Cohen, and maybe you can address also the high turnover question; what is the problem? We have had—I must tell you, my office has also had doctors coming in complaining that they have been on and off and on and off, and we see this also. I do not know what the situation is. Please tell us.

Mr. **Cohen**. I cannot really address the high turnover with respect to people in the organization. I can talk about high turnover for areas that I am familiar with and have responsibilities for.

As Dr. Sanders did say in his statement, we started to experience a higher degree of claims coming through the system in October and November of this year than we had anticipated, frankly. And the claims system that was built and designed to handle the company was designed by the Tingly Systems, which perhaps handles 20 or 25 of the HMO's nationally; it is a packaged system, which we have had in place for several years.

Some of the comments made by the gentlemen from Av-Med attribute to the situation, where we get claims in that are incorrectly completed and not have the necessary information in order to process that. We get claims in that do not have a referral or authorization. And as you should understand the HMO system, one of—you know, we—you talked about, in your opening statement, I believe, that the average Medicare beneficiary pays about $2,500 a year in health care. And in the HMO system, in the TEFRA contract designed by the Congress, it was specifically designed to bring that level of health care down, that cost down to the population.

As we all know, the cost of health care is escalating well past what the senior citizens can afford to pay, and thus the impact of the TEFRA legislation.

So, we get a lot of claims coming through the process where people do not understand the lock-in feature that is part of the HMO. The HMO's provide all these added benefits that you talked about. The tradeoff is that a member loses freedom of choice; they have to go to an HMO panel physician; the services have to be authorized; they have to be approved by a primary care physician except for urgent needed services.

So, we get a lot of claims that come through for services that were not approved. And that is not to say that they are wrong, but we have to go back and chase down the referral methods.

Mr. MICA. If I may, though, both—or all three HMO's must get those claims that are filled out improperly. The fact is, from what my office tells me and what Mrs. Skaggs says and what we have been checking is that we do not have a single complaint from anybody else, but we have a mountain of them from you. What is the difference?

Mr. COHEN. Okay. I think we must come back to some statements and perhaps—something that perhaps got a little bit lost in the conversation. We do have 147,000 HMO participants, Medicare participants in the program. The gentlemen from Av-Med said they have about 8,000 participants in the program, and only 200 in the Palm Beach—in this area, while we have 20 to 25,000 in the area.

I think we are—we may be the only other HMO providing Medicare beneficiaries the HMO opportunity in this county; if there are others, they have the same small numbers that Av-Med has, 200 or 300 or 100.

Mr. MICA. So, in brief—I hate to do this, but we need to move on. In brief, your explanation is that you are so large that you would expect this number of complaints?

Mr. COHEN. No. We are not at all pleased with the number of complaints. We are most embarrassed by the number of complaints, and the number of complaints is directly related to the fact that we have grown so fast, that the public has taken such great acceptance of the product as a cost-savings product to the senior citizens, and we have not built the infrastructure of the company as rapidly to accommodate that growth.

We make that statement openly. We are certainly displeased—I have only been with the company, in this position, for about 4 or 5 months, and it was brought in just to rebuild the financial systems, the claims systems——

Mr. MICA. What—you've been with the company 4 or 5 months. We were talking about turnover; is that a new position, or was there somebody there before you?

Mr. COHEN. No, it is frankly a new position. I was with a national CPA firm.

Mr. MICA. We just heard the regional administrator say that if things did not straighten out, he might deny certification, and he was talking about one major concern—about payment. We are getting a large number of complaints, people saying they are being dunned for nonpayment. Now, that is aside from the complaints itself, but specifically, what is the problem? Is there a cash-flow problem, do we have—do you have the money in the bank to make these payments, and the checks just are not getting out quick enough, or——

Mr. COHEN. There is not a cash-flow problem in the company. The company has sufficient assets, sufficient net worth to pay its bills as they become due.

Mr. MICA. Is it—and I may have to ask counsel, or you tell me—can you tell us how much you have in assets and how much you have outstanding in liabilities?

Mr. COHEN. We have approximately $110 million in assets and a net worth of about $13 million, therefore, liabilities of roughly $93 million; good portions of that are long-term debt, mortgages on hospitals. You know, we are a health care provider of services; we are not an insurer.

Mr. MICA. But you can insure the public that there is no problem with the cash coming in. There is enough money to pay the bills that are out there.

Mr. COHEN. We are absolutely paying our bills as we get them, as they become due. The problem with the dunning notices, and it is an embarrassment, is that as we have these problems with bills coming through the system, and because of several reasons, they are late in the payment process. Rightfully so, the physicians, the other people get upset and would like to get their money. There is no question about that.

Mr. MICA. Well, let me put it in these terms. At least from our survey, over half the public and well over half the hospitals say that they are not getting paid on time. Are the hospitals not filling out the forms correctly—how can they get paid on time?

Mr. COHEN. I would suggest that the problems that have been mentioned in this hearing about the duplication and enrollment/disenrollment creates many of those problems, in that when—there are times that we get bills where we—where a member had disenrolled, and there is a question of what period of time that the member is enrolled.

Mr. MICA. So, what you are saying is that enrollment and disenrollment problems are one of the major reasons why hospitals and individuals are not getting paid?

Mr. COHEN. I am saying that is one of the problems. When we collectively add the problems compounded by the methodology, the lockin feature of people going outside the plan, and when we add to that and our growth all those factors, coupled with the fact that we have been regrettably remiss in paying bills as timely as we would like to have them paid.

Mr. MICA. So, let me just say this again, then. You are admitting that you have been remiss in paying bills on a timely basis, but there is—you are giving us an assurance that there is money in the bank to pay all of these bills.

Mr. COHEN. Yes.

Mr. **Mica**. No question.

Mr. **Cohen**. And we are making the positive steps, the positive changes to improve the functionalization of the claims processing, so that we can process those claims within the timeframe that is acceptable in the medical community.

Mr. **Mica**. I have to tell you at this point, our information leads us to conclude otherwise, that there are other problems. We are not sure whether it is just management or infrastructure, but when you have half of the public that you deal with having these kinds of problems, it does not appear—and we will have to review our cases and the others that have been referred—it does not appear that it would be just enrollment and disenrollment problems.

Mr. **Cohen**. I do not think I said that. I said when you couple that with the——

Mr. **Mica**. With the other.

Mr. **Cohen**. Yeah.

Mr. **Mica**. Let me ask you, Dr. Sanders: You heard the statement here—we have already had some comment on delays in payment claims, but pretty strong wording here, "inadequacy and ineptness of management at IMC in their recordkeeping . . ." This incident where all of the claims from the Consumer Affairs Office were lost and asked to be refiled, can you comment on that, and is there any kind of management overview going on right now, or review in light of the current problems?

Dr. **Sanders**. Well, I think as Mr. Cohen mentioned, and as I did previously in my statement, there is a very comprehensive indepth review of management, particularly in the claims processing system, which seems to be the major focus, the major site, through which we are having our complaints, and we are not in any way condoning what has happened or trying to justify what has happened in the past. The only thing that we can do is try to effect a more appropriate system.

We think at this point in time, and if the English writer O'Henry is correct, that one can only become successful through one's failures and the recognition of one's failures. I think we have identified our weaknesses, and I think we have the wherewithal to deal with those and to comprehensively put together an administrative and economic package that will deal with the problems.

But we in no way want to deny the fact that the problems exist, but the point is that we recognize them and the effort is being made, and the resources are available to deal with them.

Mr. **Mica**. Well, let me just say, for the record, 2 years ago we had a hearing on this subject—there were complaints, and for a year and a half after that, everything seemed to be going very smoothly. It seems to be in the last 6 to 8 months that things have just really exploded on us, and we are trying to find out exactly what the reason is.

Before you respond, Mr. Cohen, I just want to get one comment on this. You heard the regional administrator say that he has no choice under law but to either have you up to 50-50 and have you meet these qualifications or revoke your certification. I would take it you would support legislation, that this committee could recommend, to give other options to the Administrator.

Mr. Cohen. I think I would totally agree with you; yes.

Mr. Mica. Well, I think we may need to talk to your legal people, as well as all the HMO's about that, because while we are talking about some specific problems, I do think to totally revoke the license of an HMO of any size could create disastrous health care problems in the community.

Mr. Cohen.

Mr. Cohen. I would like to reemphasize that, and discuss a little bit about the extent to which this partnership between the legislature and the administration, the HCFA group particularly, and the providers, and particularly IMC, because IMC is on the forefront, the cutting edge of this HMO Medicare environment. We clearly have the largest enrollment, we were clearly the prototype for the TEFRA legislation.

There are a lot of things that need to be solved with the pm. We talk about this enrollment/disenrollment, that is one portion of it. We have a situation where people go out of plan, and because of what is known as the "intermediary system," where the HCFA has delegated the payment responsibility generally to the Blue Cross Association throughout the country, there are significant instances.

There are significant instances, in 1984, roughly 2 million dollars worth of instances, where we get medical claims in for which we had no knowledge about for 6, 8, 10, 18 months. Now, that is not an accusation, that is a function of the——

Mr. Mica. Well, how do you get a claim that you have no information on and it sits there for 18 months? Does anyone call anyone and say, "Hey, we've got a claim and there's no legitimacy to it; do we wait 18 months?"

Mr. Cohen. Actually, with these out-of-State claims most of it—most of it comes through us through the actual—HCFA, out of Washington, where the claim process, for instance, is submitted to Blue Cross, Blue Shield in New York. That claim is then paid in the system, and then the paperwork is submitted up to HCFA, and then that paperwork then comes to us from HCFA.

We are trying, and we have had all kinds of meetings, and everybody recognizes this; the HMO's recognize it, the HCFA—you know, HCFA recognizes some of these difficulties; everybody is working together to try to solve these.

When we talk about—and you said that you started to experience—your office started to experience a larger amount of claims 6 or 8 months ago—that is when we started to experience it, too, and that is when the company started to take some positive changes as to what was going on.

What simply had happened is that the whole infrastructure, the computer system, the claims department, was not geared up to handle the level of activity, the level of acceptance that this company experienced, and the senior managment of this company, starting in October/November, took some very solid steps to start making changes—those changes do not happen overnight, you do not rewrite and develop new claims systems overnight.

There are a great many things that are happening that started at the same time, and they are not as a result of this hearing, and they are not as a result of actions that took place just a little bit ago. We recognized the problems as well, as we are facing up to them and taking corrective steps to solve those.

Mr. **Mica**. At this time, I am going to call on my colleague, and let me say, I would like to leave the record open again at this point for us to submit questions. There are continued concerns here. We are running out of time to do it orally at this point, but I would welcome your cooperation with legislation that gives us some options other than a total cutoff. I was not aware that this situation was as difficult or as serious as the Administrator pointed out this morning, and I hope also that you can reach the 50/50 mix that is required in the next year, year and a half, because as I understand it, you are the only one that has that waiver and it is going to be very difficult, I would think, politically, publicly, or even on an appropriations basis to continue that waiver if you have not reached it. I am concerned, I must say, and we will submit additional questions.

Mr. Boucher.

Mr. **Boucher**. Thank you very much, Mr. Chairman.

In the interest of time, I am only going to propound one question, but I would appreciate both Mr. Wilson and Dr. Sanders responding to this.

I think some of the advertising for enrollment in HMO's has been based upon the availability of the kinds of services that could be described as preventive medicine, and I understand that some doctors have questioned whether or not that preventive medical service quality really is present in some of the HMO's. In particular, it has been suggested on occasion that not a sufficient number of annual physical exams have been provided and that some basic tests, such as blood count tests and electrocardiograms, are not provided to people who are very much in need of them—cardiac patients in particular.

I wonder if you could respond to those concerns, and tell us whether your HMO's do provide annual physical examinations for all of your participants, and whether those special services are provided when they are required.

Mr. Wilson, would you like to respond first?

Mr. **Wilson**. Yes, sir, we do. As I mentioned, the Av-Med Health Plan is an independent practice association model and we contract with individual physicians to see our enrolled members in their private offices.

When a member enrolls, they must select a primary-care physician who then becomes responsible for directing all the medical care that that patient might need. We do not direct the member or the physician in terms of what type of medical care of what number of office visits or the number of procedures, or any other restrictions that the physician might feel is necessary to provide medical care that that member needs. We leave it—most of our program is left entirely up to the physician to provide the medical services that he feels is necessary for the member.

Mr. **Boucher**. So, if that physician felt that annual physical exams were appropriate and that special basic tests were appropriate, depending on the condition of the particular participant, you would provide reimbursement for those services?

Mr. **Wilson**. That is correct.

Mr. Boucher. Thank you.

Dr. Sanders.

Dr. Sanders. I would just like to underline that. Whatever medical services are required, will be provided, but I think we have to get down to a very basic issue. And that is one of—No. 1, is a yearly physical exam medically appropriate? There is very clear-cut data now in the medical literature that that is probably overutilization of medical care services.

To provide everyone a quote, "yearly physical exam," while everybody here would probably say, "Well, that sounds correct," and most physicians today would probably say, "Well, that sounds correct," from a scientific study standpoint, that is considered medically inappropriate and ineffective utilization.

The routine chest x ray that everybody suspects that they should have when they come into the hospital is not very clear, from both the medical and economic standpoint, that that is unjustified.

Mr. Boucher. Are you saying that you do not provide for annual physical exams?

Dr. Sanders. No; I did not say that. I said that——

Mr. Boucher. Well, do you provide for them today?

Dr. Sanders. Yes, we do. But the point is that the question of health maintenance, which was the original focus of your question—I think I would totally agree with you that countrywide, when we look at every HMO program, the one thing that is probably not emphasized enough is the "H" and the "M" and that is the health maintenance component, but I do not point a finger at simply the HMO. It is basic problem with our entire health care delivery system, because we are more oriented toward treatment of identified disease than we are oriented to taking care of the patient and trying to keep them from getting sick in the first place. We probably ought to go back to the ancient Chinese system in which the people paid the physician when the patient was well. As soon as the patient got sick, they stopped payment of the physician.

Mr. Boucher. I may have some additional questions to submit to you with respect to your practice of providing specific basic tests as they are needed and the record, of course, will remain open I understand, Mr. Chairman, for that purpose.

That concludes my questions. Thank you.

Mr. Mica. Thank you.

Quickly, Dr. Sanders, how many enrollees do you have in Palm Beach County, roughly?

Dr. Sanders. I think, approximately, 30,000.

Mr. Mica. 30,000. Broward County?

Dr. Sanders. I should have the answer to that, but I do not have it, and I will provide it for you——

Mr. Mica. Does somebody know with you; I would like to know, roughly, Broward, Dade, and Palm Beach?

Mr. Cohen. It is approximately 35,000 in Broward, 35,000 in Dade.

Mr. Mica. 35,000 in Dade County.

Mr. Cohen. Approximately.

Mr. Mica. 35,000 in Broward, and 25,000 in Palm Beach County. So this is a tricounty organization.

Mr. Cohen. Right.

Mr. Mica. And you are talking about now expanding into—what, Martin County?

Mr. Cohen. No. We were talking about the—Mr. Morris talked about the expansion in to Sarasota and Manatee Counties; we also operate in Hillsborough, Pinellas, and Pasco Counties, and our applications for expansion are in Sarasota and Manatee County.

Mr. Mica. Quick point: Are these complaints only coming from Palm Beach and Broward County, are you getting that type of level of complaints from Broward; are our people pickier, or are their people more easy, or—what is the——

Mr. Cohen. Our records, and my own personal feeling, would indicate that the level of complaints in the southern part of Broward County is substantially less, and the level of complaints in Dade County is even substantially less than that.

Mr. Mica. So you are saying Palm Beach County has a lot of complaints?

Mr. Cohen. There is some reason for that. As we look at the growth of the company, the company started in Dade County, Dade County is more mature; and went into Broward County, that is more mature; Palm Beach County, the company came into approximately a year and a half——

Mr. Mica. I apologize to the other witnesses; we are going to have to cut down on the other time, but this is very important now.

Are you providing the numbers of doctors and services and facilities in Palm Beach County that you are for the same ratio of patients or enrollees in Dade County or Broward County; is there some obvious reason that we can move quickly on to lessen the complaints and the problems in Palm Beach County?

If you are saying we are getting more complaints here, there might be something we could do now, not just wait for legislation.

Dr. Sanders. At the present time, the ratio of our primary-care providers and subspecialists in Palm Beach County approximate the same ratios that we have in Dade and Broward.

Mr. Mica. Is the population age group older?

Dr. Sanders. The—I cannot answer that. I cannot answer that at this point.

Mr. Mica. I wonder if we could get you to submit that for the record.

Dr. Sanders. I could.

[The material submitted by Dr. Sanders follows:]

International Medical Centers
Quality Assurance Department
Evaluation of Medical Regional Provider Network

Quarterly Report
for
April, 1986

submitted by:

David Stone
James M. Pummer, ARNP

I. SIGNIFICANT FINDINGS

According to the criteria used in developing this study, the following Medical Specialists need to be recruited to contract with IMC or an affiliated group:

COUNTY	SPECIALTY	NUMBER NEEDED *
Broward	Anesthesiology	4
	Allergy	1
Palm Beach	Anesthesiology	3
Pinellas	Anesthesiology	2
Pasco	Pediatrics	1
	OB/GYN	1
	General Surgery	1
	Ophthalmology	2
	ENT	1
	Orthopedics	1
	Anesthesiology	2
	Allergy	1
	Urology	1
	Cardiology	1

* NUMBER ROUNDED OFF TO NEXT FTE.

II. BACKGROUND

The purpose of this report is to comply with IMC's previous commitment to OHMO. We are required to demonstrate that an internal review is conducted for all wholly owned and affiliated provider Medical Centers and insure that there is an adequate and available array of medical specialists to serve our enrollment.

It is the intention of this report to quantify by county, which regions might be in need of more specialty physicians.

III. METHODOLOGY

Each provider group has the responsibility of developing a delivery system that provides the full range of services that may be needed by its enrollees. These arrangements may be made either by a direct contract between the group and specialist or by an agreement with the specialist that has already contracted directly with IMC. Ratios of specialists to members have been actuarially established for IMC based on industry norms. This report compares the number of specialists available to the number of FTE's required, based on IMC membership per county as of April, 1986.

IMC CAPACITY PLAN

Physician Staff Requirements

Industry Norms

Physician FTE Required

PHYSICIAN SPECIALTY	COMMERCIAL UNION FTE Per 1000	MEDICARE FTE Per 1000
o Internist/GP	.370	.814
o Pediatrics	.150	.000
o OB/GYN	.100	.100
o General Surgery	.065	.163
o Opthalmology	.030	.087
o ENT	.025	.038
o Orthopedics	.035	.070
o Dermatology	.020	.030
o Radiology	.040	.120
o Psychiatrist	.030	.009
o Anesthesiology	.040	.100
o Allergy	.015	.033
o Urology	.020	.080
o Cardiology	.010	.040
o Other Specialties	.020	.040
TOTAL	.970	1.724

IV. RESULTS

IMC-CAPACITY PLAN

Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Dade County

Category	All other lines	Medicare	Total
No. of Members	31,967	34,163	66,130

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	147	.370	11.83	.814	27.81	39.64
o Pediatrics	19	.150	4.80	.000	0	4.80
o OB/GYN	23	.100	3.20	.100	3.42	6.62
o General Surgery	43	.065	2.08	.163	5.57	7.65
o Ophthalmology	30	.030	.96	.087	2.97	3.93
o ENT	20	.025	.80	.038	1.30	2.10
o Orthopedics	30	.035	1.12	.070	2.39	3.51
o Dermatology	21	.020	.64	.030	1.02	1.66
o Radiology	20	.040	1.28	.120	4.10	5.38
o Psychiatrist	25	.030	.96	.009	.31	1.27
o Anesthesiology	11	.040	1.28	.100	3.42	4.70
o Allergy	2	.015	.48	.033	1.13	1.61
o Urology	16	.020	.64	.080	2.73	3.37
o Cardiology	33	.010	.32	.040	1.37	1.69
o Other Specialties	119	.020	.64	.040	1.37	2.01
TOTAL	559	.970	31.03	1.724	58.91	89.94

- Other Specialties Include: Podiatry 25 GI23 ; Neurology16 ; Oncology 13; Endocrinology 2; Thoracic & Vasc. Surg. 7 ; Nephrology11 ; Neurosurgery 7 ; Plas.Surg 4 ; Proctology 3 ; Podiatry ; GYN: 8

NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

IV. RESULTS

IMC-CAPACITY PLAN

Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Category	All other lines	Medicare Broward County	Total
No. of Members	8,995	34,658	43,653

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	77	.370	3.33	.814	28.21	31.54
o Pediatrics	14	.150	1.35	.000	0	1.35
o OB/GYN	12	.100	.90	.100	3.47	4.37
o General Surgery	16	.065	.58	.163	5.65	6.23
o Ophthalmology	14	.030	.27	.087	3.02	3.29
o ENT	16	.025	.22	.038	1.32	1.54
o Orthopedics	14	.035	.31	.070	2.43	2.74
o Dermatology	20	.020	.18	.030	1.04	1.22
o Radiology	11	.040	.36	.120	4.16	4.52
o Psychiatrist	12	.030	.27	.009	.31	.58
o Anesthesiology	0	.040	.36	.100	3.47	3.83
o Allergy	1	.015	.13	.033	1.14	1.27
o Urology	17	.020	.18	.080	2.77	2.95
o Cardiology	21	.010	.09	.040	1.39	1.48
o Other Specialties	72	.020	.18	.040	1.39	1.57
TOTAL	317	.970	8.71	1.724	59.77	68.48

Other Specialties Include: Podiatry 25; GI 15; Neurology 15; Oncology ; Endocrinology^3; Thoracic & Vasc. Surg. 3 ; Nephrology 6 ; Neurosurgery ; Plas. Surg^4 ; Proctology^1 ; Podiatry ;

NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

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IV. RESULTS

IMC-CAPACITY PLAN

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Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Palm Beach County

Category	All other lines	Medicare	Total
No. of Members	5,450	26,281	31,731

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	39	.370	2.02	.814	21.40	23.42
o Pediatrics	3	.150	.82	.000	0	.82
o OB/GYN	9	.100	.55	.100	2.63	3.18
o General Surgery	8	.065	.35	.163	4.28	4.63
o Ophthalmology	8	.030	.16	.087	2.29	2.45
o ENT	4	.025	.14	.038	1.00	1.14
o Orthopedics	12	.035	.19	.070	1.84	2.03
o Dermatology	5	.020	.11	.030	.79	.90
o Radiology	4	.040	.22	.120	3.15	3.37
o Psychiatrist	4	.030	.16	.009	.24	.40
o Anesthesiology	0	.040	.22	.100	2.63	2.85
o Allergy	1	.015	.08	.033	.87	.95
o Urology	4	.020	.11	.080	2.10	2.21
o Cardiology	4	.010	.05	.040	1.05	1.10
o Other Specialties	29	.020	.11	.040	1.05	1.16
TOTAL	135	.970	5.29	1.724	45.32	50.61

Other Specialties Include: Podiatry 12; GI 3; Neurology 10 Oncology 1; Endocrinology ; Thoracic & Vasc. Surg. 2 ; Nephrology 1; Neurosurgery ; Plas.Surg ; Proctology ; Podiatry ;
NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

IV. RESULTS

DMC-CAPACITY PLAN

Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Hillsborough
County

Category	All other lines	Medicare	Total
No. of Members	4,553	17,173	21,726

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	27	.370	1.68	.814	13.98	15,66
o Pediatrics	9	.150	.68	.000	0	.68
o OB/GYN	7	.100	.46	.100	1.72	2.18
o General Surgery	14	.065	.30	.163	2.80	3.10
o Ophthalmology	13	.030	.14	.087	1.49	1.63
o ENT	8	.025	.11	.038	.65	.76
o Orthopedics	9	.035	.16	.070	1.20	1.36
o Dermatology	4	.020	.09	.030	.52	.61
o Radiology	9	.040	.18	.120	2.06	2.24
o Psychiatrist	11	.030	.14	.009	.15	.29
o Anesthesiology	2	.040	.18	.100	1.72	1.90
o Allergy	1	.015	.07	.033	.57	.64
o Urology	7	.020	.09	.080	1.37	1.46
o Cardiology	4	.010	.05	.040	.69	.74
o Other Specialties	31	.020	.09	.040	.69	.78
TOTAL	156	.970	4.42	1.724	29.61	34.03

Other Specialties Include: Podiatry 6 ; GI 7 ; Neurology 4 ; Oncology 4 ; Endocrinology 2; Thoracic & Vasc. Surg. 4 ; Nephrology 3 ; Neurosurgery ; Plas.Surg 1 ; Proctology ; Podiatry ;

NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

IV. RESULTS

IMC-CAPACITY PLAN

Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Pinellas County

Category	All other lines	Medicare	Total
No. of Members	1,681	19,861	21,542

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	32	.370	.62	.814	16.17	16.79
o Pediatrics	3	.150	.25	.000	0	.25
o OB/GYN	10	.100	.17	.100	1.99	2.16
o General Surgery	9	065	.11	.163	3.24	3.35
o Ophthalmology	7	030	.05	.087	1.73	1.78
o ENT	5	025	.04	.038	.75	.79
o Orthopedics	9	035	.06	.070	1.39	1.45
o Dermatology	6	020	.03	.030	.60	.63
o Radiology	6	040	.07	.120	2.38	2.45
o Psychiatrist	4	030	.05	.009	.18	.23
o Anesthesiology	1	040	.07	.100	1.99	2.06
o Allergy	1	015	.03	.033	.66	.69
o Urology	4	020	.03	.080	1.59	1.62
o Cardiology	3	010	.03	.040	.79	.82
o Other Specialties	16	020	.03	.040	.79	.82
TOTAL	116	970	1.64	1.724	34.25	35.89

Other Specialties Include: Podiatry 6; GI 2; Neurology 2; Oncology 2; Endocrinology ; Thoracic & Vasc. Surg.4 ; Nephrology ; Neurosurgery ; Plas.Surg ; Proctology ; Podiatry ;
NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

IV. RESULTS

IMC-CAPACITY PLAN

-

Estimated Physician Staff Requirements
-ALL CENTERS- By Membership Class

Pasco County

Category	All other lines	Medicare	Total
No. of Members	2,427	15,659	18,086

Physician FTE Required

PHYSICIAN SPECIALTY	PHYSICIANS AVAILABLE	ALL Other Lines		Medicare		Total
		FTE per 1000	Est.FTE Required	FTE per 1000	Est. FTE Required	Est.FTE Required
o Internist/GP	15	.370	.90	.814	12.75	13.65
o Pediatrics	0	.150	.36	.000		.36
o OB/GYN	1	.100	.24	.100	1.57	1.81
o General Surgery	2	.065	.16	.163	2.55	2.71
o Ophthalmology	3	.030	.07	.087	1.36	1.43
o ENT	0	.025	.06	.038	.60	.66
o Orthopedics	1	.035	.08	.070	1.10	1.18
o Dermatology	1	.020	.05	.030	.47	.52
o Radiology	3	.040	.10	.120	1.88	1.98
o Psychiatrist	1	.030	.07	.009	.14	.21
o Anesthesiology	0	.040	.10	.100	1.57	1.67
o Allergy	0	.015	.04	.033	.52	.56
o Urology	1	.020	.05	.080	1.25	1.30
o Cardiology	0	.010	.02	.040	.63	.65
o Other Specialties	5	.020	.05	.040	.63	.68
TOTAL	33	.970	2.35	1.724	27.02	29.37

- Other Specialties Include: Podiatry ; GI ; Neurology ; Oncology 2 ; Endocrinology ; Thoracic & Vasc. Surg. ; Nephrology ; Neurosurgery ; Plas.Surg ; Proctology ; Podiatry ; Pediatrics Cardiology:1 Chiropractic: 2

NOTE: NUMBERS MAY REPRESENT DOULBE COUNTING.

Mr. MICA. All right. I do apologize for keeping you all so long, and the witnesses that are to follow you; we will have to move on rather quickly. We are supposed to clear this chamber by noon.

We will submit additional questions for the record.

Mr. MICA. Our next panel will be consumers: Eileen Rundle, Rita Kolsin, Benjamin Levine, and Mr. and Mrs. Moyer.

Ladies and gentlemen, if I could ask you to please proceed. Here is what I would like to ask you to do. I know you each have written statements, and I have your statements before me.

I would like you to just take a minute or two and summarize your experience and then we will ask some questions, and we may submit some additional questions that we want you to respond to in writing. But because we also have one more panel to go, we are going to have to speed up just a little bit.

We will start with you, Ms. Kolsin.

PANEL THREE—CONSUMERS: CONSISTING OF RITA KOLSIN, WEST BOCA RATON, FL; EILEEN RUNDLE, BOYNTON BEACH, FL; AND KATHLEEN MOYER, PALM SPRING, FL

STATEMENT OF RITA KOLSIN

Ms. KOLSIN. My name is Rita Kolsin, and I reside in West Boca Raton, FL. I have listened to a lot of things today, and I am infuriated over a lot of things. My father was rushed to the hospital on February 9, and we were informed that he needed surgery, and we could not get a doctor to assist in this surgery because IMC does not pay their bills.

These doctors are owed thousands of dollars, and they were not going to touch my father unless I came up with $3,000—I had to pay the doctors $3,000 before they were going to touch my father; I think this is a total disgrace.

What would have happened if I did not have that money to pay these doctors? This money is supposed to be sitting there—where, who is getting paid? Who is pocketing this money, where is it going? If the doctors are not getting paid, and the hospitals are not getting paid, and IMC says they are paying these things, where is this money going?

These retired people that have worked all their lives are entitled to some kind of care. The care from IMC is disgusting—totally outrageous and unacceptable. They do not have enough doctors. Their appointments are canceled week after week after week; members are not seen by these doctors. Somebody better get on their toes quickly.

Mr. MICA. Thank you.

[The prepared statement of Ms. Kolsin follows:]

PREPARED STATEMENT OF RITA KOLSIN, BOCA RATON, FL.

My name is Rita Kolsin and I currently reside in Boca Raton, Florida. My family and I moved to Boca Raton a year and a half ago and then soon after, my mother Sophie and my father Meyer Mazza enrolled in the International Medical Centers Gold Plus HMO Plan at the Medical Center of West Boca Raton.

On February 9, 1986, my father Meyer Mazza was rushed to the Northwest Regional Hospital with a suspected hot appendix and very painful gall bladder. After initial testing, we were informed that my father was to be scheduled for surgery at 8 a.m. the next morning. On the morning of February 10 at approximately 8 a.m., my father was moved into the operating room and initial preparations were made for surgery. However, we waited and waited for hours without being advised of his condition or what was occurring inside the operating room.

At 12 noon, the surgeon, Dr. Kwang-Jae Joh came into the waiting room of the hospital and informed us that he would not perform any surgery on my father because he could not locate another doctor who was willing to assist him with the surgery. When we asked why, we were informed that doctors were not willing to work for HMO simply because they do not get paid.

Needless to say, myself and members of my family immediately became frantic. Here was my father in the operating room with serious problems and in very bad pain and neither the surgeon nor the hospital would do anything for him.

At 12:15 p.m., Dr. Joh came back into the waiting room and informed us that if we paid him $3,000 on the spot, he would get an assistant and perform the necessary surgery.

When we questioned Dr. Richard Golden, chief of surgery, he informed us that he would not touch my father under any circumstances because it was time that the HMO's learned a lesson about paying their bills.

Had we not paid Dr. Joh the $3,000 in advance, there is no doubt in my mind that Dr. Joh and Dr. Richard Golden would have most certainly let my father die.

Patient delayed surgery in HMO controversy

By John Harris
Staff Writer

When U.S. Rep. Dan Mica holds his next Congressional hearing on health maintenance organizations, he can expect to get an earful.

One of those who has asked to be on the agenda of the hearing is Rita Kolsin of West Boca.

Her woes involve her parents, Meyer and Sophie Mazza, 70 and 66 respectively, who had joined the International Medical Center's (IMC) Gold Plus HMO Plan with The Medical Center of West Boca (an HMO, not affiliated with the new West Boca Medical Center hospital).

When her father had to be hospitalized, Kolsin said, they followed all the rules. He entered an HMO-approved West Broward hospital and was to have surgery performed by a surgeon assigned by the HMO.

They expected his costs to be covered under the HMO membership as they had been promised when the couple had joined.

Kolsin, her husband, Mal, and mother, Sophie, went to the hospital that Sunday morning to be with her father who was to have a swollen and painful appendix removed.

Her father was prepared for surgery and went into the operating room about 11 that morning.

But the surgery wasn't forthcoming.

"The surgeon said he couldn't get an assistant to help him because the HMO hadn't been paying the assistants. And that the hospital did not allow him to operate alone," Kolsin said.

"I got very upset. Here was my father lying there in pain. And they weren't going to do anything for him!"

She rejected a suggestion that he be transferred to a West Palm Beach hospital, stating he was in no condition to be moved.

She contacted the hospital's chief of surgery. "He said: 'I refuse to touch this man. It's about time the HMOs learned a lesson.'

"That's when I started raving," she said. "I pleaded with the doctors: 'Take care of my father now and then let's fight about the money.'"

She said the surgeon told her that if he got an up-front check for $3,000 he could hire an assistant and proceed with the surgery.

"So I gave him my personal check so he could go ahead," Kolsin said. "After all, it was my father. Even if I'd had to stand on the street corner and beg for the money to get it done, I'd have done so."

Kolsin said later the administrator of the West Boca HMO came to the hospital, gave the physician a check, and her check was returned.

"But I'm convinced those doctors would have let my father lie there and die unless he had the money in his hand," she said. "It was a horrible scene.

"I think that the HMOs should pay the doctors. But I believe the doctors are placing compensation above a human life."

Kolsin said she plans to ask the Congressional committee, which Mica plans to bring to the area within the next two months, to investigate where the money the government is paying the HMOs is going if the HMOs are not paying the doctors.

And her parents are dropping out of the HMO, she said.

George H. Picaza, administrator of The Medical Center of West Boca Raton HMO, said the situation was a "highly unusual" one.

"This was an emergency," he said. "Generally our cases are handled by St. Mary's Hospital (West Palm Beach).

"When I learned of the situation, I went right over because I wanted to make sure our patient was taken care of.

"But I do not approve of the doctors' tactic. I think they should treat the patient before being concerned about payment. I think it's a sad statement that some physicians are so money hungry that they would resort to this."

But the surgeon, Dr. Kwang Jae Joh, sees it differently.

"That was a terrible experience," he said. "I was caught in the middle. The hospital will not allow me to operate without an assistant surgeon. But I couldn't get an assistant because the HMO doesn't pay them.

"So I had to tell the family that they would have to get an assistant surgeon or they could pay me up front so I could hire one. They gave me their check. I got an assistant, and did the surgery.

"Later the owner of the HMO came in, gave me his check, and I gave the family's check back to them."

Dr. Joh said the problem is that the HMOs are not paying the doctors for their services.

"Some HMOs have owed me a lot of money for over two years and haven't paid a penny," he said.

"Some HMOs have paid me a little — others none. Yet, month after month, I've been taking care of their patients. Then I've asked them to pay me, but they don't.

"It finally gets to where you can't stand it any longer. When that happens they just move to another physician, and then another, and another. They can do this because todays physicians are eager to get patients.

"They shouldn't be using us this way," he concluded.

Barbara Ferreiro, director of public relations at IMC's Miami headquarters, said the firm's analysis shows 90 percent of the HMO's medical claims are paid within 30 days.

But the doctors interviewed said this has not been their experience.

Dr. Richard Golden, chief of surgery at the West Broward hospital, confirmed Dr. Joh's contention that the reason most surgeons don't want to assist in HMO cases is that they have had too many bad experiences in not getting paid.

"I'm owed about $15,000 from two HMO franchises on bills going back a couple months," he said, adding that there are other cases in which physicians do not get paid at all from HMO franchises.

"Yet every time a doctor takes a case, he stands the chance of losing every penny he ever made (in a malpractice lawsuit).

"I don't mind doing surgery without pay when its needed by an indigent person. But I do mind doing it for an HMO franchise that has gotten paid and then doesn't pay me. Too often these franchises have taken advantage of us.

"For this reason, a lot of good specialists now refuse to get involved with HMOs.

Dr. Golden said Picaza had offered to pay him to assist Dr. Joh in Mazza's surgery. "But it wasn't a matter of money that morning," Dr. Golden said. "Mr. Mazza's case was not presented as an acute emergency — one in which an hour or so was going to make a difference — and I had a very important appointment that morning," he explained.

Mr. **Mica**. And I want to ask you a few questions about that.

Mr. **Mica**. Ms. Rundle.

STATEMENT OF EILEEN RUNDLE

Ms. **Rundle**. My name is Eileen Rundle and I live here in Boynton Beach at 325 North East 24th Avenue. I am the daughter of an 82-year-old former International Medical Center patient and would like to share this résumé about the lack of competent care he received from IMC over the past 2 years.

Just before Christmas 1984 my father was having a lot of medical problems. The IMC doctor recommended an upper GI series and other x rays which were interpreted to be a stomach ulcer, and other x rays which were said to be cancer of the bone—from which he is slowly and painfully dying. His IMC doctor called and said that at his age there wasn't much that could be done other than keeping him comfortable with pain killers.

A few months later he had a recurrence of a urinary problem and was given medication and referred to a urologist in South Hollywood. Two days before the appointment—which was made 6 weeks after the acute episode—he went over to the HMO to see if there were any x rays or reports he should take with him to the appointment and was told no, they had been forwarded already. When we arrived for the appointment—I took a half day off work to accompany my father—the urologist couldn't help him since the HMO had neglected to send him any pertinent information, so that was a complete waste of time not to mention again prolonging medical attention.

In December 1985, my father had another acute urinary obstruction and was in severe pain. This occurred in the middle of the night and the emergency number we were given to call on such occasions was busy for half an hour so I took my father over to the hospital emergency where an indwelling catheter was inserted and we were instructed to see the IMC doctor the next day for followup treatment. Again—this was in December. When my father went to see the IMC doctor the next day he was told to just keep his appointment which had already been scheduled for February 1986. A 2-month wait. During this period he continued to have problems with the catheter for he was never given any instructions on how to care for it by the HMO. He was then referred to a visiting urologist at the HMO office for early February. When we arrived for this appointment the urologist was not there and according to that office this particular urologist was never there in the afternoon—I had taken another half day off to go with my dad, again to no avail.

The following week when my father did see a urologist, he suggested prostate surgery, even though the IVP wasn't done until a week later. The hospital he was to be admitted to was Doctors' Hospital in Plantation. When we hadn't heard anything from IMC by February 28, I contacted Congressman Mica's office to see how we should go about disenrolling. They were very courteous and told me what to do, so we went to the HMO and signed the necessary papers to disenroll.

At the moment, although I understand technically he should have been disenrolled March 1, we are still awaiting written notification that he is back on Medicare at which time he will be admitted immediately by the private urologist we saw for the much needed prostate surgery at which time a biopsy will be done. It is the opinion of the private urologist that this surgery should have been done 2 years ago.

To add insult to injury is the fact that the IMC does not live up to its contract promise of paying all bills incurred. An August 1985 bill is still not paid to Delray Hospital and we have received word that the next contact for payment will be through a collection company. This, in my opinion, is unnecessary mental anguish for which there is no excuse.

I hope this insight into one patient's experiences with the International Medical Centers will help this hearing to decide on some kind of action to help other senior citizens who are unable to help themselves.

Mr. Mica. Mr. and Mrs. Moyer.

STATEMENT OF KATHLEEN MOYER

Mrs. Moyer. My name is Kathleen Moyer and I offer this statement on behalf of my husband, Ted Moyer, and myself. We reside at 227 Woodlands Road in Palm Spring. The statement I will read is a synopsis of my file with Congressman Mica's office which I would like to submit in its entirety for the record.

My family signed up for the Gold Plus Plan late in 1984. My mother's first appointment was December 7 with a followup on December 20 as she had found out that she had emphysema from our family doctor the year before and we all thought the soreness she was experiencing was due to that and that she would be taken care of.

In February 1985, the doctor saw her again and I believe that time he discovered a lump in her left breast and set up some type of scan to be done in March. That test showed nothing.

In April she was worse, called to make an appointment in May—it always took a month to see a doctor.

In June, my father fell and broke his toe. My sister took him and my mother to the HMO emergency on Hypoluxo. My mother was so worked up over my father that when they got there, the nurses and doctor took my mother in, checked her heart and told her that she was physically exhausted. In the meantime, my sister was going crazy trying to get someone's attention for 45 minutes to get our father out of the car and take care of him.

It took 3 weeks after the doctor at emergency notified mother's other doctor before he saw her again. He said something about her having an ulcer and treated her for one—with no tests ever being done.

In July, we took her to emergency again. She was getting worse and we weren't getting anywhere in finding out what the problem was although we knew it had to be more than emphysema and an ulcer. This time her doctor saw her in 5 days.

He set up for a liver and pancreas scan for 2 weeks later—we heard no results.

She then had an appointment to see her doctor a week after the test on August 9—but a nurse called and canceled setting up another appointment to see a specialist, August 19.

By this time my mother was completely bedridden and in a lot of pain.

By August 13th she went to emergency again, by ambulance this time, because she couldn't move. The doctor there told her she had accute arthritis and didn't even want to hear about her other symptoms.

We couldn't believe what was going on—we did not understand any methods that the HMO worked by.

My mother by now, had seen her doctors seven times and gone to emergency three times in 8 months and they still wouldn't help her. I called the complaint number which is posted at the doctor's office but I really didn't feel that I accomplished anything.

I called Palm Beach Medical Society, they referred me to an IMC representative, Mr. Fowler. He asked me to write a letter to Dr. Sanders in Miami, and, to explain the problems we were having. I did. But I also sent that letter to five other people hoping to get some results. I felt soon after I wrote that letter that all we had to do was mention my mother's name and we received immediate attention when before we always got a runaround.

The specialist saw my mother and he knew right away that something was very wrong—he called the doctor at HMO while we were still in the office and asked him why it had been 6 weeks since he had seen his patient and to set up a series of tests at the hospital because he wanted a biopsy of the left breast—he didn't understand why it had never been done—a bone scan, and a stomach biopsy.

The specialist took her off all but two of the medications she had been put on by the other doctors. It was also at this time that we fully realized what my mother was going through with some of the other doctors she had seen. She kept on telling the specialist over and over again what all her symptoms were as fast as she could—I had to stop her from talking. In my opinion, the specialist knew what was wrong and reassured her that something would be done and that he knew she was very ill. She seemed so relieved.

I asked her about it when we left. She told me the other doctors didn't believe her and just wouldn't listen. From then on I went with her to see any doctor although she was only 65 years old—just so she wouldn't feel intimidated again.

My mother had the bone scan done and the biopsy late in August.

On September 5 I took my mother to see the surgeon who performed the biopsy. It was through him that we learned she had cancer and the reason for all her pain—the cancer had spread from her breast to her ribs and spine.

All the reports went to the HMO office. We saw the cancer specialist and he explained about the chemotherapy treatments and set up her first treatment for a week later. When the time came to have her first treatment, he found out she was too weak and her blood count was too low and he put her in the hospital to build her up.

She was there 8 days, she came home October 3, and an appointment was set up for October 17 to begin chemotherapy. Again we could understand this wait—we didn't think mom could get worse but she did. We also were never given answers to why she couldn't have treatment in the hospital—maybe there was a reasonable explanation but no one ever explained.

We took her back to the hospital October 6. It was then that we met Dr. Villa and found out that the cancer had spread to her liver, kidney, and lungs and it was too late for any treatments.

My mother was in the hospital for 12 days; she came home October 17 and she died October 20.

I have never received any answers to any of my questions from IMC.

Mr. **Mica**. Ms. Moyer, that is why we are trying—this hearing is being held today to try to get some of these answers.

Let me ask you first. Is it your feeling that your mother had not been referred to a specialist quickly enough?

Mrs. **Moyer**. That is my feeling.

Mr. **Mica**. That is your feeling. And also that once it was determined that she had cancer, that there were, as you indicate, mixups in dates for treatment for chemotherapy?

Mrs. **Moyer**. Right. I think that it was too late, that they really did not realize she had bone cancer until after she had seen the specialist. My mother had been there since late 1984, and it was not until August 1985 that she first saw a specialist—and for months she was bedridden and still they could not find anything. They came up with acute arthritis, she did have emphysema, and it was an ulcer, stomach ulcer, created her pain, but cancer was not mentioned once.

Mr. **Mica**. Well, let me say this to be very fair. Diagnosis or misdiagnosis is one problem; delay and lack of referrals to specialists is something that we can zero in on and try to do something about.

We will look, as we already have started, very, very carefully at your specific case.

Ms. Rundle, you indicated in your testimony that you had been told that surgery should have been done 2 years prior to when it was finally done.

Ms. **Rundle**. Yes. This was by a private urologist that we went to see.

Mr. **Mica**. By a private doctor. How long had your husband been a member of an HMO?

Ms. **Rundle**. This is my father, sir.

Mr. **Mica**. Your father.

Ms. **Rundle**. Yes. In May 1984, and we were just told this by the private urologist in February 1986.

Mr. **Mica**. And he had gone in for diagnosis of this problem all during that problem?

Ms. **Rundle**. Yes; he had gone in for regular visits, but he had never been referred to a specialist or, as I said, when he was referred, not enough data was sent, so nobody was able to help us. And he did not receive the—one particular test—until he had seen the last HMO urologist, so I do not know yet whether they have come up with the fact that he does have cancer of the prostate.

Mr. **Mica**. Well, I think that is one area that we have identified in our own survey; 36 percent of the respondents said that they were adequately referred to specialists. So, it is an area that we are going to look into in very great detail.

Ms. Kolsin, you indicated that the doctors told you they could not treat the patient because HMO had not paid its bills?

Ms. **Kolsin**. Yes.

Mr. **Mica**. A doctor told you this?

Ms. **Kolsin**. Yes. The doctor——

Mr. **Mica**. I do not—do not mention names.

Ms. **Kolsin**. I will not. My father was prepped for surgery at 8 o'clock in the morning, and by 12 noon had not heard anything other than see the surgeon walking back and forth in the corridor of the hospital. He finally came into the waiting room and he informed us that he could not do the surgery, because he could not get an assistant to work for HMO because they were not getting paid. Not unless we gave them $3,000, on the spot, would they touch my father.

Mr. **Mica**. Mr. Boucher.

Mr. **Boucher**. No questions.

Mr. **Mica**. Obviously, there is a great deal that we are going to have to do to look into these specific cases, and I tell you—and I say this for the record—well over half of the people who responded to our survey were pleased with their service from HMO's. These three panelists represent three or four individuals who were selected from hundreds who requested to testify. This is meant to give us some idea and show some idea of the types of problems that we have.

Each of the problems will be referred; if they are minor problems, through my office and through HCFA, and ultimately IMC to be corrected. If there is what we consider inappropriate or negligent action, it will be referred to the inspector general.

So, we thank you very much, and we appreciate your being with us.

Mr. **Mica**. Our last panel. Dr. Lee Fischer, and I know him and he is on his way up; Dr. Milton Tignor, from the Palm Beach County Medical Society; and Rodney Dorsette, administrator of Doctors Hospital.

As you can see, the panels were broken down into four groups: the first one, Federal and State agencies; the second, HMO representatives; the third, a sampling of consumer people who are customers, if you will; and the last, the medical profession from here in Palm Beach County.

Let me welcome you and ask you to begin. We have to clear this chamber by noon, so we will move right into the testimony.

Dr. Fischer, please proceed.

PANEL FOUR—MEDICAL PROFESSION: CONSISTING OF LEE A. FISCHER, M.D., PAST PRESIDENT, PALM BEACH COUNTY MEDICAL SOCIETY; MILTON TIGNOR, M.D., PRESIDENT-ELECT, PALM BEACH COUNTY MEDICAL SOCIETY; AND RODNEY DORSETTE, ADMINISTRATOR, DOCTORS HOSPITAL, LAKE WORTH, FL

STATEMENT OF DR. LEE FISCHER

Dr. FISCHER. Mr. Chairman and members of the committee, thank you for the opportunity to appear before you again to discuss health maintenance organizations in Palm Beach County. I am Dr. Lee Fischer, past president of the Palm Beach County Medical Society and a board-certified family physician practicing in West Palm Beach. On July 9, 1984, I had the opportunity to testify before the Committee on Health Maintenance Organizations and the Elderly: Promises, Problems, and Prospects. In the 2 years since HMO's invaded our county with their expensive advertising campaigns, I have been intimately involved in the controversy. My remarks today will focus on the promises, problems, and prospects in the 1¾ years since your last hearing. I hope my views and opinions will be helpful to you and other Congressmen who will be faced by bewildered citizens in their districts as Medicare HMO's expand nationwide.

Medicare HMO demonstration projects began in Palm Beach County on January 1, 1984, with the promise of quality health care with little or no charge to the patient, including many services and benefits not generally covered by Medicare. Did the HMO's keep their promise to the Medicare population? In my judgment, no. My testimony in July 1984 focused on five areas of concern. I will briefly list those areas and comment on problems that have persisted since then.

Enrollment practices were a severe problem initially due to the public's perception of HMO's being markedly different from reality. Since both State and Federal Governments mandated that consumers be given more facts and since door-to-door solicitation is now illegal, this problem may have been partially corrected. I am still concerned with the basic motivation behind a capitated system which seems to be to enroll as many people as possible (and generate monthly payments) and worry about delivering medical care later.

Disenrollment problems still linger and were addressed by the General Accounting Office report of March 8, 1985. There may still be people falling prey to bureaucratic redtape and finding serious delays in getting disenrolled. Although HCFA has mandated that disenrollment be processed rapidly, it is still in the financial interest of the HMO to keep people enrolled as long as possible.

Quality of care is an area of tremendous concern which can have devastating consequences. Anecdotes abound that demonstrate substandard medical care, but they do not necessarily prove that one system of medical care delivers better care than the other. I am extremely concerned, however, with the basic economic philosophy underlying HMO's: the less money they spend on the patient, the more money they retain as profit. Because most HMO's receive a capitation payment for each individual enrolled, they have a built-in financial incentive to deliberately underutilize medical care. In my opinion, any system that tries to control costs by instructing physicians to cut corners and deliberately underutilize medical services against the physician's better judgment is only paying lip service to quality patient care. I am worried that a large number of people who know nothing about health care, but a lot about making a profit, are forming their own HMO's so they too can get a piece of the pie. The public needs protection from unscrupulous businessmen who will be enjoying the good life in Europe while their former HMO members hunt for a new health care provider.

I believe that the major problem with HMO's in Palm Beach County is the continuity of care. Problems we identified to you in July 1984 persist, including the fact that many of the HMO centers are not private physicians' offices, but rather free-standing clinics, who hire part-time doctors to service not only their walk-in episodic-care patient, but also their chronically ill Medicare HMO patients. The doctor who is on duty Monday may not be the same one who is on duty Tuesday. He may even be a semiretired doctor who wants to earn a little extra money while he is down here relaxing for the winter. Many HMO doctors have no hospital privileges and, therefore, the HMO's must rely on private practitioners at local hospitals to care for their patients—a fact that leads to poor follow-up and a total fragmentation of the patient's care.

Very few HMO doctors are board certified in the specialty of family practice, although one HMO tries to make people think that its doctors are specialists by stating in one of their ads that their physicians are, quote, "licensed in general or family practice, internal medicine, or pediatrics." There is no such thing as being licensed in a specialty. Continuity of care also includes whether the HMO itself will be around in the future to service its members. Local newspapers have documented a number of stories of HMO franchisees going out of business. At least one Palm Beach County HMO, which initially embraced the Medicare HMO concept, has pulled out of the Medicare market entirely.

Our fifth area of concern, in July 1984, was resolution of patient concerns. As senior citizens encountered problems which could not be resolved, they turned to the Palm Beach County Medical Society and their local Congressman. The fact that Congressman Mica called this hearing today proves to me that patients' concerns are still not being resolved satisfactorily. Is there something inherently wrong with the HMO system that patients' problems can only be resolved by involving their Congressman, or is the problem with the HMO operators themselves? About 3 months ago I participated in a call-in TV program on HMO's. Most of the callers' complaints were the same ones I have been hearing for 2 years, and the HMO representatives' standard reply was, "Yes, that is a problem, and we are working to correct it." They cannot hide behind that answer forever, as they found out from the larger number of dissatisfied people. I suggest that the committee ask the HMO's why people cannot get a solution to their problems internally, without congressional involvement.

What do I see is the prospects for HMO's in Palm Beach County? I think HMO's are here to stay, although I disagree with many who think they will be the dominant health care delivery system of the future. No matter what the system is called—HMO, PPO, IPA, fee for service—patients still want a caring physician who will listen to their problems and treat them with respect.

For 2 years now, I have urged people to get all the facts about any health care system, and specifically to find out who the doctors are who will be delivering their medical care. No matter how good the HMO is, the individual physician is the only person who is actually licensed to practice medicine. The quality of the care each patient receives should belong in the hands of the doctors and not in the hands of a businessman.

Mr. Chairman, it has been a privilege to appear before you again to express my concerns about HMO's in Palm Beach County. I will be glad to answer any questions.

Mr. MICA. Thank you.

Mr. MICA. Dr. Tignor.

STATEMENT OF DR. MILTON TIGNOR

Dr. TIGNOR. Thank you, Mr. Mica, committee members.

I am Milton R. Tignor, Jr. I am a board-certified urologist in Palm Beach County, and am president-elect for the Palm Beach County Medical Society. I was to testify in this committee, and it was basically the quality of care, and I would like to deviate from dealing with HMO's in order to discuss alternative health care systems in general, because that is where we are.

The cost of medical care has been escalating—you can read it in the papers, you can read it everywhere. That is the reason for HMO's and alternative care; it was set up to decrease medical care.

In the last statements, 10 percent of our national budget was said to be going for medical care for our people, and this was wrong. The problem has to be addressed, as in 1965, when Medicare became an entity. We like to know that a percentage of Medicare people over the age of 65 then, compared to the dollar spent, and also the number of Medicare-aged people today under the program, and the dollar being spent per capita on that patient. And I think the ratio would give us if that system is really costing us too much, or is it the number of people that are living past 78, that our medical system has developed for them to live and enjoying 15-plus years of retirement life. I think it is worth that to the people to enjoy their retirement with excellent-quality medical care.

Another item I would like to address is that the HHS Secretary, Dr. Otis Bowen, is considering a ruling by the previous acting administrator of the Health Care Finance Administration (HCFA) that recommends that a circulating nurse in the operating room not be a registered nurse, but they replace that nurse with an LPN, a licensed practical nurse or a surgical tech, in order to cut costs in the hospital nursing facilities.

This is certainly not quality of care, and the Joint Commission of Accreditation manual on Standard 12.4.5, page 133, states that, "Only a qualified registered nurse may act as an operating room supervisor, head nurse, or circulating nurse. A licensed practical nurse or a technician can only circulate under the supervision of a registered nurse."

I bring this up in alternative health care systems where they are interested in cutting costs. This is one factor where the quality of care can not be maintained if these people—this ruling from HCFA comes down that they can use them.

When the federally mandated diagnosis-related groups—DRG's—and the PRO's—peer review organizations—get their health care length of stay in hospitals set up, it is set up—another item that I would like to talk about, and that is the health care industry.

Under the new program, HHS is attempting to dismantle and cut down the health care benefits that are now being proposed by the Medicare or the people leading the hospitals, and this is cutting down on the patients' ability to obtain hospital care because of the DRG's, and then when they go home with health care, they are trying to cut the services at this point—again to cut medical costs, and I am questioning whether this is a medical quality that we are dealing with.

The American public deserves the best system, and I have cut some of my testimony short here for some time. They not only deserve it, we will demand it. The Government mandated, regulated, and rationed the medicine tied in with all alternative-care delivery systems. I think this can only reduce quality, and I think this is what we are interested in these days, is quality of medicine.

Thank you for allowing me to make my statements. I will answer any questions.

[The prepared statement of Dr. Tignor follows:]

PREPARED STATEMENT OF MILTON R. TIGNOR, JR., M.D., WEST PALM BEACH, FLORIDA

Mr. Chairman and members of the committee. Thank you for the opportunity to appear before you to discuss Health Maintainence Organizations of Palm Beach County. This should really be Alternative Health Delivery Systems. I am Dr. Milton R. Tignor, Jr, a Board-Certified Urologist, practicing in West Palm Beach since 1971, and President-Elect of the Palm Beach County Medical Society. Alternative Health Delivery Systems in HMO; PPO; IPA; IPO; and net-working organizations in Corporate industry are increasing greatly in our county, all vying for control of some part of the Medical Dollar. I think that it is the cost of quality medical care that we are here to discuss.

We are told that the Medical Health Cost is 10% of the National Budget - around Three hundred ten Billion Dollars - which is a great increase over the 1965 costs. What has to be addressed is the number of people over the age of 65. What was the number of people over the age of 65 in 1965 compared to the number of people over the age of 65 today? Only then can a cost-comparrison be made. Once this is done, the quality of care can be assessed against the cost. Does our first-class medical system really cost too much? Does it cost too much to allow our population to live to an average age of 78, 13 years beyond 65 year-old retirement?

Example of an item affecting Quality of Health Care:
HHS Secretary Dr. Ottis Bowen is considering a ruling by the acting administrator of the Health Care Finance Administration (HCFA) which recommends that the circulating nurse in the operating room not be a Registered Nurse , but rather a technician or a Practical Nurse. This is certainly not a quality of care. In the accreditation manual of the Joint Commission of Hospital Administration in 1986 Standard 12.4.5 page 133 states "only a qualified Registered Nurse may act as an Operating Room Supervisor; Head-Nurse, or Circulating Nurse. A Licensed Practical Nurse or technician can circulate only under the supervision of a Registered Nurse." This may be a way an Alternative Health Care System can curtail cost, but at the risk of curtailling quality. This needs to be addressed by this commission on its effect on quality of care.

With the Federally mandated Diagnosis Related Groupings (DRG's), with hospital stays approved by Federally mandated state Peer Review Organizations (PRO's), the Home Health Care Industry has flourished. HHS is attempting to dismantle the medicare home health care benefit; at the same time HHS policies are increasing the number of medicare beneficiaries who need health care. Spurred by the office of Management and Budget, HHS has sought, by a series of extraordinary arbitrary, and sometimes questionable illegal measures, to restrict the growth of Home Health Care. For example: eliminating the favorable presumptive statute and barring payment of more than one home visit per day in some cases. HHS justified the limitation by citing a doubling of medicare expenditures for home care and in the number of certified home health agencies since 1980.

The Federal Government has tried to cut rising medical costs by mandated rules governing hospital admissions, pre-admission certifications, and increased out-patient procedures. However, this has led to an increase of home health care costs. Is this cost justified? To have the health care patient leave the hospital one day early - to make use of the home health care facilities so the hospital cost decreases, but now finding home health care costs increasing. Then having the budget directors trying to curb this cost. Where is the quality? Is the cost, in the light of our aging population, too much? Shall we become a second rate medical nation? Shall our patients get decreased medical care because of living too long and cost more because of their health needs? A monumental problem with no quick-fix answers like we have been given from the Federally mandated programs. Again, Alternative Health Delivery Systems using these mandates only curtail quality.

The American public deserves the very best medical system. Not only deserves it, the will demand it. Government mandated, regulated, and rationed medicine tied in with all the Alternative delivery systems can only reduce quality.

Mr. Chairman, it has been a priviledge to appear before you to express my concern of quality health care in Palm Beach County. I will be glad to answer any questions.

Mr. **Mica**. Mr. Dorsette.

STATEMENT OF RODNEY DORSETTE

Mr. **Dorsette**. Mr. Mica, members of the panel, I am Rodney Dorsette, administrator of Doctors Hospital in Lake Worth.

Doctors Hospital operates a very busy emergency room, one of the busiest in the county. We have an annual visitation of patients in excess of 22,000. Doctors Hospital has experienced problems in the Emergency Department in securing approval from International Medical Center HMO–IMC, when one of its enrollees presents in the emergency room. The emergency room and/or the attending physician devotes considerable time in attempting to obtain an authorization for treatment by a physician that we are trying to obtain permission from.

In an emergency, the EMS physician and the attending physician needs to be caring for the patient, not talking to IMC. Our physicians and the hospital have had difficulty obtaining authorization from IMC, and we are not comfortable with the high risk in which we are placed when IMC insists that a patient who is experiencing a high-risk episode be transferred to a facility contracting with IMC.

It is only fitting and proper that this hearing should have been held on April 1, because many of the recipients are led to believe they have coverage, and when they encounter a high-risk episode, they find out it is April Fool's Day and they are not covered or they are jerked around.

Attached are minutes from a subcommittee of the Emergency Department which had to be impaneled because of the major problems this hospital and its medical staff have experienced in securing HMO authorization to treat a patient who presents in the Emergency Department. Also enclosed is correspondence regarding this issue.

The problem is still unresolved. You have heard testimony today about accounts being paid. I have proof of two patients—account No. 7047396 and No. 7021835—with outstanding balances owed by IMC of $10,349.75 and $18,952.17, respectively—the last one dating back to July of 1985. We are told that they want to do an audit on the last account. The patient will not sign the permission with the audit, and we have no alternative but to turn the account over to a collector.

Thank you very much for letting me testify.

[The material submitted by Mr. Dorsette follows:]

E.D./HMO SUBCOMMITTEE
MINUTES OF MEETING

A meeting of the ED/HMO Subcommittee was held on January 9, 1986, at 12:00 noon in the Medical Library.

Those in attendance were: Dr. Zeltzer, Dr. Heller, Mr. Dorsette & Mr. Bradford.

HMO Form

The committee discussed problems experienced in the Emergency Department in securing approval from International Medical Center HMO, when one of its recipients (enrollees) presents in the Emergency Room. The committee felt that the emergency room physician and/or the attending physician should not be involved in securing permission through the 800 number designed for contacting the HMO. It was the feeling of the committee that an information form should be designed that would be completed prior to the 800 number being called to obtain approval. The form would insure that the same information is gathered on all HMO patients presenting in the Emergency Department and would document the fact in a clear and concise manner. Administration was instructed by the sub-committee to design such a form that would be placed in use to facilitate contacting the HMO and not involving the physicians, who were better utilized in attending to the patient. The form will be designed and will be presented to the Medical Record Committee for approval.

There being no further business, the meeting was adjourned.

Respectfully Submitted,

Rodney F. Dorsette
Administrator

**Doctors
Hospital**

February 27, 1986

Jack Zeltzer, MD
Chairman, Emergency Department Committee
2887 Lake Worth Road
Lake Worth, FL 33461

Dear Jack:

Enclosed is a copy of a letter from Dr. Kaine, Executive Director of the IMC-Gold Plus Plan of the Palm Beaches. During a recent meeting with Dr. Kaine, I informed him in as blunt a manner as possible that Doctors Hospital was not interested in any form of contract with IMC now or in the future. During further discussion, I was able to explain the many problems that our physicians and the hospital have experienced with securing approval from IMC and the high risk in which we are placed, when IMC insists that a patient who is experiencing a high risk episode be transferred from our Emergency Room to a facility contracting with IMC.

Please place this letter on the Agenda of our next Emergency Department Committee Meeting in order that we might review it with the total committee and then share it with the Executive Committee of the Staff. By a copy of this letter, I am forwarding Dr. Kaine's correspondence to Dr. Yount and several of our key staff in order that we might utilize Dr. Kaine's plan, when the next IMC patient presents in the E.R.

Sincerely,

Rodney F. Dorsette
Administrator

jw

cc: Harold A. Yount, MD
Chief, Emergency Department Physicians
Mr. Al Hargrave
Asst. Administrator
Mr. Larry Bradford
Controller
All Physician Members of E.D. Committee

IMC-Gold Plus Centers of the Palm Beaches
A Federally Qualified Health Maintenance Organization

Administration
1901 South Congress Avenue, 4th Floor
Boynton Beach, Florida 33436
(305) 737-6880

RICHARD KAINE, M.D.
Executive Director

February 20, 1986

Mr. Rodney Dorsett
Administrator
Doctor's Hospital
2829 10th Avenue North
Lake Worth, Fl. 33460

Dear Mr. Dorsett:

I thank you for the time you devoted to our meeting. The information which you shared with me is extremely valuable to me.

I have confirmed my initial impression. All that is required in patient admission certification is a call to IMC. If you have not received a return call by one of our physicians within 30 minutes authorizing the admission, then you are at liberty to proceed with an implied authorization. The bill is then essentially guaranteed. Your only further step would be to notify IMC that the admission has in fact taken place. There is no need for you, your Director of Nurses, or the Assistant Administrator to become involved in time consuming telephone calls. It is the obligation of our staff to return telephone calls to physicians or hospitals wishing permission for admission within 30 minutes. In the interest of the patient, if this has not occurred, the admission is authorized by default. I hope this will ease the burden on you, your staff, and eliminate difficulties for our patients.

I hope sometime in the future to have an improved relationship with you and with Doctor's Hospital. In the interim if I can be of any service please let me know.

Sincerely,

R. Kaine

Richard Kaine, M.D.
Executive Director
IMC-Gold Plus Plan of the Palm Beaches

RK:cm

OFFICE OF THE ADMINISTRATOR
FEB 24 1986
DOCTORS HOSPITAL OF LAKE WORTH

Mr. Mica. Thank you.

Let me say this: One observation, again, and I cannot emphasize it enough. I personally think that HMO is a healthy concept, that it has some good ideas. I think there are some major problems here. I also think, as our doctors' panel has pointed out here, that quality health care is the goal that we are all attempting to achieve.

I must say after nearly 20 years in public service, though, that there is concern over costs as well. What we want is not just quality care, but care that can be afforded and care that is accessible. You can have the best quality in the world, and if nobody can afford it—we had that situation in some cases some years ago, it does not help, either. You can also have lesser quality, that everybody can join in, and then not get the kind of care you want—and that creates a problem, so we are trying to balance this out.

Dr. Fischer, one quick question, first. One of our HMO representatives testified that you do not—you may not need an annual physical and that is overutilization of care. For over 60 or 65, is an annual physical optional?

Dr. Fischer. It is optional in the fact—I tend to agree that not everyone in this country needs an annual physical complete with all blood tests, x rays, and EKG's every year—that is very true. I think when problems arise, people should have them taken care of. I think everybody over the age of 65 should at least have a baseline physical that could be done—not necessarily even at one visit, but over the course of three or four visits over a year; have blood tests run at one visit, a chest x ray at another, an EKG at the other, but whether everybody needs one every year, that is probably true that they do not necessarily need a physical if they are feeling perfectly fine every year.

Mr. Mica. Let me ask you a little bit about payments or lack of payments thereof. We have had quite a bit of testimony today about payments not being made to hospitals or doctors. Can you give us any information you have on that subject?

Dr. Fischer. Yes. That has been a chronic problem since they began in January of 1984. I talked to some doctors in the hospital today; they still have outstanding bills to IMC for care that they rendered in emergencies back in 1984 even.

It is a chronic problem; doctors just do not get paid. I had one patient, that was a patient of mine, that later joined the HMO, that I ended up caring for in the emergency room, because I was on call and on duty for the emergency room. It took 7 or 8 months for me to get paid, only after I hassled the heck out of them and got delays and delays and delays. Finally they wanted to look at the—they were waiting to look at the chart before they paid the bill—on an admission that was an emergency that was even authorized by IMC, and I had copies in my office, and they paid the bill.

We did—it is totally out of control; it has not changed in 2 years. And I would just like to say, Mr. Chairman, that the private doctors in Palm Beach County who are on call for emergency rooms—like myself, like Dr. Tignor, have been covering for the fact that IMC has not been able to get enough doctors to take care of patients, whether they are specialists or general practitioners.

Doctors Hospital has no contract with IMC at all. People come in there—I saw one doctor in there taking care of four emergencies for IMC—two heart attacks—putting them in the hospital, and I would just like the public to know that it is the private doctors in this county who are taking care of the patients that go in the hospital, not IMC for the most part.

Mr. **Mica**. Could I ask Dr. Sanders to come up, if you do not mind? I would like to pursue this for just a moment here.

This is a point that is being raised by non-IMC physicians: oftentimes we have had letters in our office saying, "I went ahead and did this work, but I do not expect to get paid."

We come back to the doctor-patient ration. Is the Federal minimum standard that you are meeting, or even exceeding, enough, or is it—what explains what we are talking about right here?

Dr. **Sanders**. There is an easy explanation for it. If a patient comes in with an acute emergency, that individual has got to go to the closest medical facility for that care. If we do not have a contractual relationship with that hospital, or if we do not have physicians on that staff, that individual has got to—if that individual is unstable, then that patient has got to stay within that hospital facility and be taken care of, hopefully, by the physician staff.

I am sure what Dr. Fischer says is correct, that patients have ended up in Doctors Hospital emergency room with emergent situations and have had to have been taken care of by the hospital staff there. They should be paid for their—you know, for their services.

We do not have to, by Federal regulation—and I do not know any HMO in the country in which they have physicians in every hospital and contracts with every hospital. If we do not have a contract, the major issue is not, "Go to the hospital where we have a contract," the major issue is, "If you have an acute emergency, go to the closest hospital."

Mr. **Mica**. Well, now, Mr. Dorsette, I live near the Lake Worth Hospital—if I come in there and I am an HMO member, will you take care of me?

Mr. **Dorsette**. Yes, sir. We will treat you, and in the meantime, we are authorized and we are told by IMC that we must secure an authorization number for payments. So we will be calling an 800 number in Miami to secure that payment.

What I am objecting to is if I have a patient with an evolving MI, and my physician says they are unstable and cannot be transferred, I object strongly to the other end of that telephone saying, "Transfer them anyhow, they're okay," and that happens.

Dr. **Sanders**. I would agree totally with Mr. Dorsette. I think if there is any situation in which we are asking an unstable patient to be transferred, we need to know about, we need to look at it, and we need to do something immediately about that.

But one other issue, that Mr. Dorsette brought up, and that is the statement that the doctor's time is being wasted trying to get authorization on an emergency case. Every hospital in every county in which we participate is aware of the fact that any IMC patient that comes in with an emergency, no authorization is required for initiation of therapy—at all.

Mr. **Mica**. Well, now—OK, I will accept that for the moment, but what we have here—you are shaking your head, Mr. Dorsette; that is not the case?

Mr. **Dorsette**. That is not true.

Mr. **Mica**. It is just simply not so?

Mr. **Dorsette**. That simply is not true. In fact, within the last 5 weeks, a Dr. Kane came to my office about this telephone call, because we were having trouble. That simply is not true. I must call and get that 800 number authorization.

Mr. **Mica**. For an emergency patient?

Mr. **Dorsette**. For emergency patients; yes, sir.

Mr. **Mica**. For anyone.

Mr. **Dorsette**. For anyone.

Dr. **Sanders**. That is just absolutely not true.

Mr. **Mica**. Well, we are not going to sit here and have both sides say it is not true. We would like to have the documents, and I would like to have my staff talk with your people about the instructions you are under to get these approvals, and we will do the same with Dr. Sanders here.

Dr. Sanders, you are saying that you do not disagree, but that this is not the case; Mr. Dorsette is saying that he has to do it, and if he does not do it, your people are in there riding him about it. So, we will have some of our staff investigators, take a look at this. We are obviously not getting anywhere here.

Now, the $18,000 payment that was not made, that has not been made: Have you had other instances like this where after you have waited a year, it turns out that IMC was not liable, and maybe these are cumulative and appear to be worse than they are, but after they are resolved, it turns out it is not a liability at all?

Mr. **Dorsette**. Mr. Mica, I do business with probably 100 or better insurance companies, HMO's, PPO's, and third-party payers. IMC is the only company that I have ever had to resort to write your office to get a payment, and I have done that probably on 8 to 10 different occasions to get payments, and after I write you and you look into it, then the check comes within 6 weeks. That is deplorable.

Mr. **Mica**. Mr. Boucher.

Mr. **Boucher**. Mr. Chairman, our time is about up. I have only one question, and that will be for Dr. Fischer.

You very appropriately, I think, Dr. Fischer, have emphasized that quality of care is a very important consideration when we evaluate the success of HMO's in general, and you have suggested that there are some serious problems in this area.

One thing that I was very interested in was the testimony from Mrs. Skaggs, earlier today, that her office has received no complaints with respect to the nine HMO's operating in the county with the exception of IMC.

Now, that being the case, to what do you attribute the absence of complaints with respect to those other nine; are they operating well, is quality of care not a problem with regard to them? What is your observation with respect to those nine?

Dr. **Fischer**. Well, first of all, IMC is bigger, they have more patients, and the other HMO's—Av-Med was here—are to some extent different. Independent Practice Association goes out and contracts with private physicians who will see the patient in their own office; IMC has some of those, but, like I emphasized in my testimony, a lot of them are just centers where they hire doctors to come in.

So, I think that is part of it, is people get a relationship with one doctor who is already in practice and he is going to be there awhile—he is just not going to come and go. I think there is a bureaucracy at IMC that probably makes the Federal Government look like it is a very efficient organization— that is part of it too.

Mr. **BOUCHER**. Well, would it be fair to say that the other nine HMO's appear to be operating reasonably well and that there is a pretty high level of participant competence in their operations as evidenced by the absence of complaints?

Dr. **FISCHER**. Well, I cannot judge the other HMO's, but there are 300 and something HMO's across the country, the concept has been around for many years. There are good HMO's and bad HMO's, and they all operate differently. I think some of the problems that have been brought up today are very good, they have been going on for 2 years, and I am thrilled that the committee is looking into them.

Mr. **BOUCHER**. Well, let me see if I can get your answer shortened down to a "yes" or a "no."

With respect to those nine, are you personally aware of any problems that have arisen with regard to the nine, other than IMC?

Dr. **FISCHER**. Yes.

Mr. **BOUCHER**. What—are they quality-of-care kind of problems?

Dr. **FISCHER**. I have not heard of any quality-of-care issues—at least brought to my attention—but one HMO, that one of the guys that I take call with was involved in for awhile, he finally got out of it because of the paperwork and some of the other hassles, "Don't do this test, don't do that test," yes. And that is not IMC, it is a different one.

Mr. **BOUCHER**. Thank you very much.

Mr. **MICA**. We thank each of you for being with us.

Let me just, in the interest of fairness, Dr. Sanders, if you have anything as a closing statement or comment you would like to make.

This hearing was not held to pick on IMC, it worked out that way. My staff indicated to me that the largest number of complaints was with IMC, but I was not aware, until this hearing today, that there was so much concern with one and, obviously, the largest.

But I am, I must tell you, much, much more concerned leaving this hearing today than I was at any time prior to coming in this room. We have had complaints, and I have dealt with complaints on Medicare and the Veterans' Administration and Social Security for 20 years, but this is the first time I have had this kind of a focus in one area; the problems with payments, and so on, appear to be pretty widespread.

IMC has recognized, at least in their testimony, that there is a problem and that they are attempting to solve this problem. That is important, but that is not enough. We are going to have to see some solid resolution to these problems. If they continue at the rate they are, my office cannot handle it. We just cannot. I cannot even get into my phones from Washington any more, because of this particular problem.

Uppermost, I think, in my mind and in the concerns of people here, is that 100,000-plus people have health care and health care policies that they are concerned with. We do not want to get into a situation, as was described here by the Regional Administrator, where the entire certification is pulled. I think that is something we need to look at very quickly—that if you do not meet these standards that we, in the first place, find a way to make sure you do and will meet them, but also that we do not leave 100,000-plus people without some type of care.

Lastly, I think it is our responsibility to safeguard what appears to be $1 billion-plus Federal investment. As I have repeatedly said here today, as I can, the concept is a sound one, has been tried and proven in many ways, but there appear to be some problems. Maybe it has to do with growth, it may have to do with management, some of the items that each of the witnesses has pointed out, but obviously the problems are far greater than what I assumed as I came into this hearing.

So, let me just thank each of you for being with us, and remind you, if you have a comment or statement that you would like to be part of the official record, you have 7 days to submit it; it will become a part of this testimony. It will be available for all of the Aging Committee members, and then the other committees in Congress that would take action to pass legislation to try to assist in this problem.

I thank you very much. The full Committee on Aging is adjourned.

[Whereupon, at 12 p.m., the subcommittee recessed, to reconvene at 2:30 p.m., the same day.]

HEALTH MAINTENANCE ORGANIZATIONS AND THE ELDERLY: PROMISES, PROBLEMS AND PROSPECTS

TUESDAY, APRIL 1, 1986

House of Representatives,
Select Committee on Aging,
Margate, FL.

Afternoon Session

The committee met, pursuant to call, at 2:30 p.m., in the Commission Chambers, Margate City Hall, 5790 Margate Boulevard, Margate, FL, Hon. Dan Mica (acting chairman of the committee) presiding.

Members present: Representatives Mica and Boucher.

Staff present: Diane Birnbaum, district administrator; John Gersuk, press assistant; Jill Benson, assistant; Nancy Ainger, assistant, Betsy Bellows, assistant; Andy Bouchlas, assistant; and Darcy Robinson, assistant; of Representative Mica's staff.

OPENING STATEMENT OF CHAIRMAN DAN MICA

Mr. Mica. The full Committee on Aging will come to order.

Let me just start our hearing with a few ground rules, if I may. First, if you have any individual problems or complaints or concerns, we have members of our staff here who will take notes on individual problems.

Today's hearing is preset panels for testimony. This testimony is a part of the U.S. House of Representatives Select Committee on Aging. It will go into a prepared bound testimony to be used by other committees when they review legislation and possible changes in dealing with health care and with—in this particularly case, HMO's.

We have set up four panels. The first will be Federal and State witnesses to talk a little bit about what they're doing to oversee the situation at the Federal level. The second will be, of course, representatives from HMOs. The third will be consumers, the public; some representative cases of some problems that we have been hearing, and last would be the Broward County medical profession.

And let me just say, we have been inundated with calls—people who would like to testify and have something to say. We tried to pick two or three cases that we think are representative of the types of problems that we are hearing, and we invite you, if you have an individual problem, to bring it to our attention, or if you have anything that you would like to say to be made a part of the official record, to submit it in writing and we will do that. And as a part of these proceedings, I will ask officially in just a moment, that the record be left open for 7 days so that any testimony that you want to submit in writing will be made a part of this official hearing.

We are not here to condemn or praise HMOs, but more to look at the overall situation, see where some of the problems are emanating, some of the concerns that our office has had, and listen to some of the positive points as well.

We had one hearing earlier this morning. It went, I think, very well, and I appreciate your understanding; we put out a number for an HMO hot line, to call and give us information as to whether you have had some positive experiences or negative experiences, and so on, and that number has been lit up to the point where it is just about useless now, because we just cannot get all the calls that are coming in.

So, I would advise, please, if you have some comment, try to put it in writing and drop us a note.

Let me just start out by saying, too, that every hearing that the Congress conducts has pre-set witness panels, be it a Washington-based hearing or a field hearing. In order that a hearing is considered official, we need a court reporter and we need at least two members. We wanted to look into HMO's in this area, and I'm very please that we have a Congressman from Virginia here today, Congressman Rick Boucher, also a member of the Select Committee on Aging. I appreciate your presence. Representative Boucher has a long history of involvement in health-related issues and is listening very carefully to this testimony. He has a personal interest in HMOs, and was just talking to me earlier today about the potential impact they will have on every district in the Nation, including his own in Virginia.

So, we are very pleased to have him here—and welcome you, and appreciate your participation.

Let me just do this—I will not read my entire statement, but simply say that the purpose of the hearing is to examine the efficiency of what we call a new system of health care, HMOs, health maintenance organizations. We want to know if the system is working, where the problems are, what the problems are, and how can we solve the problems. I will just say that from my own standpoint, having worked in and out of Government in public positions for nearly 20 years; I have seen HMO's and I have seen them do an excellent job. Kaiser-Permeniti out in California, Georgetown University in Washington, DC, and others have done a super job. They have provided adequate and excellent health care and are praised by all who review them.

In South Florida we have a little different situation. We have an explosion in the growth of participation in HMOs—with that there are growing pains, some that appear pretty severe, that we are going to try to zero in on and see what we can to do correct. And that is the purpose of this hearing.

An HMO, as far as I am concerned, is just another way to deliver health care. Some of you may have gone to hospitals, others to clinics, others to out-patient facilities, and maybe others to group practices. All of those are like an HMO; a different way to provide health care. They are no worse and no better than the people who run them. And some that grow as rapidly as we have seen here today are obviously going to have some problems.

We have had, I must say, a dramatic increase in the complaints with regard to HMOs in Palm Beach and Broward County. The Federal Government is footing the bill for most of the senior Medicare programs, in fact, over $1 billion a year of taxpayers' money goes into HMO payments, and that is a large amount of money. One of our tasks here is to try to protect that investment and oversee it properly to make sure that it is spent appropriately.

We conducted a survey on HMO's our district, some of you participated in it. We tried to locate the areas where we thought we had the most participants in HMOs, and we had 45,000 people respond. Some of their concerns related to items like this—and I will not read it all, but we asked the question, "Does your HMO provide prompt payment to your doctor bills," and the answer was 50 percent, no.

"Does your HMO provide prompt payment of your hospital bill," 54 percent, no.

Now, to be very fair to the question, "Are you satisfied with HMOs" 76 percent said, in effect, they were satisfied; about 24 percent, nearly a fourth, said they were not satisfied.

On the question of emergency care, almost a third said they were not getting referred for adequate emergency care.

On the question of deceptive claims, "Do you feel that HMOs have made exaggerated or deceptive claims about its services or benefits," 43 percent said yes, that they did see a problem with the advertising.

So, although we are not here to single out any given HMO or to say the concept is bad, we recognize when you have a substantial minority of discontented members it is worthy of public hearings and an attempt to make sure that if there is a solution to the problems, that we find that solution and do everything we can in a calm, reasonable, rational manner to focus on that.

[The prepared statement of Representative Mica follows:]

PREPARED STATEMENT OF REPRESENTATIVE DAN MICA

I would first like to welcome my colleague from the House Select Committee on Aging to this hearing, and thank him for taking the time to join us today. Rep. Frederick Boucher (D-Va.) has a long history of involvement in health-related issues and has proven himself an able and dedicated advocate for older Americans.

The purpose of this hearing is very clear: To examine the efficiency of the dramatic and relatively new health care concept known as Health Maintenance Organizations. In short, we want to know whether the system is working. Florida, with its large elderly population and disproportionate share of HMO consumers, is the ideal laboratory in which to study the issue.

Our studies on the Aging Committee project that by 1990, the average senior citizen in this country will spend $2,583 a year on health care -- nearly 19 percent of his income. With medical costs already consuming 15 percent of the average senior's income, it is clear that HMOs are a viable health care alternative.

Just how viable is clear from national and statewide enrollment statistics. There are 480 operational HMOs nationwide today with more than 20 million members. That enrollment figure is up from 14 million just two years ago.

In Florida alone, there are 32 HMOs with about 650,000 members, up 50 percent from 1984. There are about 70,000 HMO members in Palm Beach and Broward counties. The vast majority of them are senior citizens. In fact, nearly 4 percent of all Medicare beneficiaries nationwide, or about 1.1 million men and women, have turned to HMOs to control their out-of-pocket medical expenses.

The federal investment in HMOs is staggering. In 1985, HMOs received more than $1 billion in federal monies. I am determined to safeguard that investment.

For months, my office has been flooded with letters and telephone calls asking for information and advice about HMOs. I will be blunt. Many people are dissatisfied. I will concede that satisfied customers rarely contact their congressman. But the volume of negative feedback demands that the matter be looked into firsthand. The most serious complaints are being investigated by my staffs in Florida and Washington, the Aging Committee, and the appropriate federal agencies.

Before I release the results of a districtwide survey I conducted last month, I will say that HMOs as a health care concept are neither good nor bad, just as a hospital or an outpatient clinic is neither good nor bad. Like all institutions, their quality hinges on the dedication of the men and women who staff them.

But I was deeply alarmed last month when I received the results of my HMO survey of Palm Beach and Broward counties. More than 4,000 men and women responded to the poll. The findings, while not strictly accurate in the scientific sense, provide an excellent barometer of local public opinion toward HMOs.

The survey results follow:

1. Have you or members of your family disenrolled from an HMO because you were dissatisfied with the quality of care?

   YES...24% NO...76%

2. Have you had problems enrolling or disenrolling?

   YES...27% NO...73%

3. Are prescriptions readily available?

   YES...87% NO...13%

4. Does your HMO provide prompt payment of doctor's bills?

   YES...50% NO...50%

5. Does your HMO provide payment of hospital bills?

   YES...46% NO...54%

6. Have you ever had difficulty obtaining test results?

   YES...31% NO...69%

7. Does your HMO provide adequate referrals to appropriate specialists?

   YES...64% NO...36%

8. Does your HMO provide adequate referrals to hospitals?

   YES...70% NO...30%

9. Does your HMO provide adequate emergency care?

   YES...68% NO...32%

10. Do you feel that your HMO has made exaggerated or deceptive claims about its services or benefits?

    YES...43% NO...57%

On the face of it, this survey demonstrates that a majority of HMO members are satisfied with the quality of care they are receiving. I am delighted that this is the case.

But what concerns me is the substantial minority that is deeply dissatisfied with HMO care. What disturbs me is the fact that one in four members are so unhappy they quit; that one third do not feel emergency care is adequate; that nearly half say their bills are not paid on time.

We are not here today to praise or to condemn HMOs. We are here to learn whether a multi-billion dollar health care system that affects 20 million Americans is as efficient as it should be.

Our oversight will not stop here. Congress and the Aging Committee will continue to monitor HMOs to assure that members get what they pay for.

At this point, I would like to invite members of the audience who wish to submit relevant material to the official record of these procedings to take advantage of the forms made available by our staff.

I also would like to announce that I have established a special "HMO Hotline" in my office to collect additional information on HMOs. The hotline can be reached by dialing (305)732-4002 and will be operational until May 15. The information we collect will be delivered to the appropriate government agency for suitable action.

Mr. MICA. Let me call on my colleague, Mr. Boucher from Virginia, to make any opening statement he may wish, and then we will call on the panels.

STATEMENT OF REPRESENTATIVE RICK BOUCHER

Mr. BOUCHER. Thank you very much, Mr. Chairman.

I appreciate this opportunity to join you here in south Florida today for the purpose of examining the subject that is of interest not just here, but nationwide.

The use of HMO's is growing. There are presently 332 federally qualified HMO's nationally, and 28 HMO's were federally qualified during the first 10 weeks of this year alone. With 20 million enrollees nationally and 80,000 participating physicians, HMO's have already become a very significant means of delivering health care services and great growth is expected in the future.

Under ideal conditions HMO's can be highly advantageous to their participating members. They can ensure that patients receive all of the services Medicare provides as well as some extra services Medicare provides as well as some extra services that Medicare does not provide; such as eye care, prescription drugs, hearing aids, and dental services. Beyond that the enrollees are not responsible for deductible expenses of coinsurance charges the way they are into Medicare.

But under less than ideal circumstances problems associated with some HMO operations have been noted. There have been delays in processing information concerning both enrollment and disenrollment of members. That leads to uncertainty as to who is responsible for charges that are incurred by patients during that lag time between the patient, the HMO, and Medicare.

Questions have been raised about the quality of services that are provided and whether the range of services provided is as great as the promises that are made for services during the time that HMO's are advertising for membership.

Prompt payment by HMO's of doctors' charges and hospital charges also have been a much noted problem.

It has been suggested that some HMO's will not pay for hospital stays that are sufficiently long to provide proper treatment.

Since HMO's are available today in many parts of the Nation, and will be available in many other parts of the Nation in the very near future, the Congress has a great interest in examining how well they are serving the needs of their members. We need to find out how well they are functioning and determine what can be done to address they are encountering to make sure that they function better.

In south Florida, you have had the Nation's most intense experience with HMO's. So, I think it is highly appropriate that our House of Representatives Select Committee on Aging is holding this hearing in south Florida today for the purpose of letting us have the benefit of your experience.

I want to commend your Congressman, Dan Mica, for giving the Aging Committee this opportunity. He is known in the Congress as a friend of older Americans. He spends a great deal of time addressing your concerns, and his colleagues in the Congress, of which I am one, greatly appreciate that fact. And the fact that he has scheduled this hearing, I think, is further evidence of the concern that he has for this problem that you are facing.

So, Dan, I want to thank you very much for giving us this opportunity and I look forward, with you, to hearing the evidence today.

Mr. **Mica**. Well, thank you very much.

We will now proceed with our first panel of witnesses. We have with us George Holland, the regional administrator for Health Care Financing in Atlanta. He is the man that oversees our regions for HMO's, and also Clyde Galloway, of the Florida Insurance Commissioner's office, Bill Gunter's office, and he is one of the people who oversees the State jurisdiction of HMO's.

While they are taking the table, let me just tell you, if you did not know this, there are 480 HMO's in the United States with 20 million members. And that figure, incidentally, is up from 14 million; an increase of 6 million from just 2 years ago, so they are growing rapidly in the United States.

In Florida there are 32 HMO's, and that figure is up 50 percent from 1984. I understand 70,000 people in our area, Palm Beach and Broward County, are members of HMO's. In fact, if you take Palm Beach, Dade, and Broward County, membership is probably over 200,000 people, 150,000 anyhow.

Nearly 4 percent of all the Medicare beneficiaries nationwide—over 1 million—are now turning to HMO for their out-of-pocket medical expenses.

So, it is a good concept. Even if there are problems and problems we have to address and correct, the concept is catching on nationwide. We are exploding in growth right here in south Florida, and we have experienced some unique problems.

With that, Mr. Holland, please proceed.

PANEL ONE—FEDERAL AND STATE OFFICIALS: CONSISTING OF GEORGE HOLLAND, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; AND CLYDE GALLOWAY, FLORIDA INSURANCE COMMISSIONER

STATEMENT OF GEORGE HOLLAND

Mr. **Holland**. My name is George Holland and I am the regional administrator of the Health Care Financing Administration for Region IV. I am pleased to be here today to discuss the administration of the HMO program under Medicare.

Medicare payments to HMO's have been authorized since the program's inception. Initially, prepayment authority was restricted to part B. Prepayment organizations were permitted to receive 80 percent of their reasonable costs. HMO's could also elect to bill Medicare on a fee-for-service basis. Neither approach was consistent with the operating philosophy of HMO's, that is, to accept in advance a fixed per capita payment, regardless of the medical services actually rendered.

With the Social Security amendments of 1972, some progress was made in providing a reimbursement mechanism consistent with HMO operation.

Mr. **Mica**. Mr. Holland, if I may interrupt.

That entire statement is included in the record from this morning's hearing, and I do not want to stop you from reading any pertinent parts, but we would like to continue with the questions from this morning. Could you summarize—just go through and summarize all the high points of your testimony—we will ask you both to do that—then we can get into the questions a little sooner.

Mr. **Holland.** All right.

Mr. **Mica.** As I indicated to the public, we had a hearing earlier this morning in which some of these witnesses, the Federal witnesses in particular, have already testified; they have submitted complete lengthy testimony. I think for our purposes here today we can just highlight it, and we will go right into the questions about it.

Mr. **Holland.** All right.

We feel the capitation of HMO's are the wave of the future. It is a good program, and it will continue to grow throughout the country.

We have some unique situations in Florida. Our International Medical Center HMO down here, which entered into a contract in June 1981, has had many administrative problems that we are addressing.

Recently the FBI and the Office of Investigator, HHS, locked and seized records from two clinics in Davie and Fort Lauderdale, and we are investigating allegations that the current and former employees of health screening of potential enrollees, and also fraudulent billing on the part of IMC subcontractors. Obviously, this is a very violation of Medicare principles under HMO's, and we are looking into that.

Now, in the past IMC has blamed their subcontractors, saying that, "It is a bad apple." Our position is over a time, however, that with each new incident, we have to look at IMC to control their subcontractors to ensure that we get quality service throughout the region.

Now, it is equally unique that IMC is a very large program and, obviously, the complaints and problems would be commensurate with their size.

To meet the qualifications for an HMO, you must have 50-percent enrollment of commercial and 50-percent enrollment of Medicare. When the program started up, we allowed demonstration projects that did not adhere to this principle and then when TEFRA was passed, we, in fact, said that the 50-percent rule does apply, and some large demonstrations, like IMC, did not have the time to enroll the commercial persons in the plan. Consequently, we granted them a waiver of 3 years, which runs through March 1988, to be able to bring up their commercial enrollment. We think this is what makes IMC atypical of the HMO's across the country—that they did not have that healthy balance of commercial enrollees in the plan, which we insist on with all risk contracts when TEFRA was passed.

This, in fact, makes sure that they can deliver high quality services and also provides effective medical and financial management. If they do not meet this, they cannot enter the plan.

Now, in order to limit IMC's growth under the waiver, the Acting Administrator of HCFA recently informed IMC that it

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would not be able to expand into any new areas unless the 50-percent rule was adhered to; consequently, I will also be monitoring their performance closely and ask for a plan of corrections to see if they can come up with the 50-percent enrollment on the commercial side by March 1988.

Another development that has happened is that we have just picked up, from Public Health, the Office of Maintenance Health Organizations, and those are the folks that actually certify the HMO to be federally qualified. We think that this will give us a great deal more flexibility and also give wider visibility to the HMO's.

One of the first projects that the OHMO will do will be to conduct a vigorous review of IMC operations to determine whether they are still in compliance with Federal requirements. The OHMO review will review such areas as: Quality and availability and accessibility of services; financial viability and stability; grievance procedures; marketing techniques; enrollment and disenrollment procedures; medical management; adequacy of IMC monitoring of its contractual relationships with subcontractors.

Where problems are uncovered, IMC will have 30 days to develop a remedy or face having its federally qualified status revoked.

In addition to this effort by OHMO, we plan to utilize the services of a medical quality review organization in south Florida to review the activities of certain subcontractors in regard to quality issues. Also, my staff will be increasing its oversight of IMC and its subcontractors.

In conclusion, we feel that the HMO's are the wave of the future and it is our highest priority to make sure that the care provided our beneficiaries is top quality. We are prepared to take whatever steps are necessary to ensure that this plan meets the requirements of the contract with the Medicare program.

We firmly believe that the capitation program is working to the benefit of both our beneficiaries and the Federal Government.

I want to thank you for this opportunity to discuss these issues with you.

Mr. Mica. Thank you, Mr. Holland.

Mr. Holland, did you hear all of the testimony this morning?

Mr. Holland. Yes, we did.

Mr. Mica. Because I want to ask you some questions.

Mr. Galloway, from Bill Gunter, the State insurance commissioner's office.

STATEMENT OF CLYDE GALLOWAY

Mr. Galloway. Thank you, Congressman. On behalf of Commissioner Gunter, I would like to express my appreciation of being invited to this hearing.

The HMO industry in the State of Florida is regulated concurrently by the department of insurance and the department of health and rehabilitative services. The department of insurance's responsibilities extend to oversight of the financial capability and the day-to-day operation from the contractual standpoint, both with subscribers and providers. HRS is charged with the responsibility of reviewing the quality of care provided to a particular subscriber by the individual HMO.

As we have seen through our review of the progression during the last 13 years, since HMO's became a regulated industry in the State, the growth has proliferated at a great pace. In 1975, there were only 4 licensed HMO's; in 1980, we have expanded to 8, and as of today, we now have 38 licensed HMO's, with 19 pending applications. This is a tremendous growth, which is serving a population of somewhere around three-quarters of 1 million Florida citizens.

In our regulatory scheme of thing we have come across several problem areas—some of which we have actual control over, some of which are outside the realm of our jurisdiction, but conceptually one of the problems that we encounter frequently is a lack of understanding by the citizens as to how the concept works.

HMO is an alternative health delivery system, which is somewhat different from traditional insurance. There has been an awakening or education of the public since the great proliferation in south Florida, but there are still some problems with people actually understanding how it works.

Another problem area, that we have experienced, has been the advertising and some of the methodologies employed in disseminating information about particular HMO's, or how the concept works.

There has been one particular incident where the department negotiated a settlement of a situation that arose to the satisfaction of the parties that were involved, and that did involve advertising.

Another problem area which we come across frequently is the enrollment and disenrollment of Medicare subscribers. Of course, another large area is the quality of care, but the majority of that work is done by HRS; however, the department does, at times, receive complaints submitted to it of that nature.

Again, let me thank you for the opportunity to be here, and if you have any questions, I will be happy to respond.

Mr. MICA. All right. Thank you.

Mr. Galloway, very specifically, with regard to financial solvency of HMO's; Do you require any kind of a bond or dollar amount set aside for HMO's operating in the State?

Mr. GALLOWAY. There is an insolvency protection in the statute, that was passed this last session, which requires, I believe, a bond or some other capability within the HMO financial structure itself.

Mr. MICA. How is that structured; is that a dollar amount or a percentage?

Mr. GALLOWAY. It is usually a dollar amount based on the valuation of the HMO total.

Mr. MICA. Do you know what the amount is?

Mr. GALLOWAY. It would be on a case-by-case basis; it can fluctuate.

Mr. MICA. All right. Do you have any information that any HMO's in the State are bordering on insolvency or have solvency problems?

Mr. GALLOWAY. We have some that we are watching. Again, you run into the problem with HMO's using GAAP accounting methods, wherein they are allowed valuation of certain assets that differentiate from the statutory method. There are problems that we are looking into to fathom out whether the particular assets should be valued at the level that it is carried on its books.

We have in the past—I believe it was in late 1979—we did have an HMO that had to be rehabilitated; in fact, it was sold before we had to liquidate the company. So the department does carry on an on-going review of the financial picture of each of the HMO's.

Mr. **Mica**. Do you breakdown the dollars-in, dollars-out profit basis?

Mr. **Galloway**. Yes, sir. That is in one of the schedules that was submitted.

Mr. **Mica**. Do you have that for each HMO in the State?

Mr. **Galloway**. Right.

Mr. **Mica**. Is that public record?

Mr. **Galloway**. When it is submitted; yes, sir. The law was changed last session to allow HMO's to submit their annual financial statement either by April 1, or by 3 months of the close of their fiscal year.

Mr. **Mica**. In reviewing that, have you seen any trend either due to lack of payments or any other warning signs that there is any kind of a problem with solvency of any major HMO?

Mr. **Galloway**. Lack of payment is an indicator, but the books themselves, at this point in time, have not indicated that they have crossed the threshold statutorily to create a situation which would require an official action on the part of the department—either to revoke or suspend the license.

Mr. **Mica**. What do you do when you find a problem in the making where an HMO might turn insolvent?

Mr. **Galloway**. If we identify a trend, then we would inform the principals of the HMO that that trend is in existence and would demand that they provide some corrective-action plan to be submitted to the department, for its review, in hopes that the threshold would never be crossed. If the threshold is eventually crossed, the department has two options available to it; it can either move in the Circuit Court of the State of Florida to seize the company and operate it pursuant to chapter 631, seizure order, or it can move to revoke the license to operate in the State, which would be an administrative process.

Mr. **Mica**. Are there any HMO's subject to that order at this time?

Mr. **Galloway**. No, sir, there are not.

Mr. **Mica**. No problems.

Mr. **Galloway**. None that have crossed the threshold at this point.

Mr. **Mica**. None that have crossed the threshold. That means that you are watching some?

Mr. **Galloway**. Yes, sir.

Mr. **Mica**. Mr. Holland, what is the per capita amount paid to an HMO for Medicare?

Mr. **Holland**. Per patient per month?

Mr. **Mica**. Yes.

Mr. **Holland**. $214.

Mr. **Mica**. $214 per month?

Mr. **Holland**. Per month.

Mr. **Mica**. Per patient?

Mr. HOLLAND. It varies by the county; by Federal register, some counties may be $214, some would be lower, some would be higher. It would depend on the county, but you could use $214 per month.

Mr. MICA. Is there any way that you can look at an HMO's overall payments? Earlier this morning we said that IMC, I believe—and correct me if I am wrong—gets $30 million a month——

Mr. HOLLAND. That is right.

Mr. MICA [continuing]. $30 million a month in Federal payments, and what their ratio of payments in and payments out are as opposed to what they are getting from the Federal Government. Do you judge how they are operating, either efficiently profitwise or solvencywise?

Mr. HOLLAND. Well, we give them a set amount based on what we rate each patient as, and then that is their amount, and then they are allowed to charge a fee, which we call their adjusted community rate, for each patient.

Now, we go with the 95-percent ratio—in other words, we will pay up to 95 percent, and then they can spend that money within their business organization.

Now, we are concerned, and when our team comes in here next month they will be looking at the total financial picture, that we have been talking about, and discussing that with the insurance commissioner.

Mr. MICA. Well, now let me just ask you: In the region that you oversee, or nationally, are we paying enough for HMO's to make a decent profit and still provide healthcare?

Mr. HOLLAND. I think we are. I think it is a realistic figure and we seem to be doing quite well.

Mr. MICA. And I guess that is notwithstanding the testimony this morning, for the record, that we——

Mr. HOLLAND. As I indicated this morning, I think one of the problems that we have in Florida is the large number of subcontractors. Now, we have paid the parent organization, IMC, and they deal with their subcontractors by paying them a capitation check every month, and then it is up to the subcontractor to take that money and pay his bills to the different providers and, you know, vendors in the area, and I think that is where some of the breakdown is; the subcontractors are not keeping up with their bills, and there might be some question of solvency of the individual centers.

Mr. MICA. Of the subcontractors.

Mr. HOLLAND. Right.

Mr. MICA. Well, you mentioned earlier, the FBI and the inspector general's office looked into two subcontractors; are they looking into any other?

Mr. HOLLAND. At the present time, I am not sure, but I am sure it is——

Mr. MICA. Then there is no other——

Mr. HOLLAND. Not that I know of. But we are very concerned about many of the subcontractors—not from the criminal intent situation, but the quality and payment.

Mr. MICA. What kind of concerns?

Mr. HOLLAND. Late payment, quality concerns in some of the areas, disenrollment practices, this type of thing; and when our team comes in here, they have a list of the individual items they are going to be looking at.

Mr. Mica. Well, after this morning's hearing, I mentioned that I would request a full audit of IMC, but as I understand it, you are going to do that anyhow; am I correct?

Mr. Holland. This will not be a full audit. It will be going in and doing a program audit and an integrity audit of the operation. As far as a fiscal audit, OHMO types, and the reason I am not that familiar with it, we just received this branch last week, and I am not that familiar with their operation, but I do know that they look at the books, but I do not believe they do a full audit.

Mr. Mica. Well, let me tell you what my concern is, and say this for the record. If any HMO, IMC or others, is not getting paid enough, then we ought to see about trying to pay them more. But if HMO's are all getting aid enough and most of them are making profits and one of them just is not functioning right, then we are going to have to do what we can to try to bring them up to speed.

You are both talking about problems with one, and until this morning we had no idea—or I had some idea, but not as focused as we had in the testimony, that that one was IMC.

I do not want to be unfair to IMC. They are the largest in the district; a majority of their people are pleased, but what needs to be done, in your estimation, to bring them up to speed so we do not have these problems?

Mr. Holland. A number of things, and I think we are starting to move on them now. We have a new branch that will be coming in here—not only looking at them as far as certification, but providing direction to better handle it. We have been dealing with the prime contractor, IMC; I feel we should have been dealing much more with the subcontractors, and we will start doing that shortly.

The quality assurance thing bothers us, too, and we will be contracting with an organization in south Florida very rapidly to go on in independently and start looking at the quality problems. Those are three or four things we can do.

Mr. Mica. Do you have any questions about the solvency of any of the HMO's in Florida?

Mr. Holland No, I do not at this time, but, obviously, if there are late payments, you do become concerned.

Mr. Mica. Well, it is a concern, and I must say that as—

Mr. Holland. But at the same time, our people in Baltimore tell us they are not concerned on the cash flow in and out, we seem to be all right, an it could be the subcontractors being delinquent, or there could be a problem—I am not sure.

Mr. Mica. You both say, "No concern at this time and they have not passed the threshold," but in your statement this morning you said that if IMC did not come up to speed, you had no choice but to withdraw their federal certification.

Mr. Holland. But this would be more than just fiscal concern, this would be quality, disenrollment, enrollment, a total spectrum.

Mr. Mica. Well, now once you have your quality assurance review, will that be on a continuing basis?

Mr. Holland. Yes, it will.

Mr. Mica. And that will be operated out of south Florida?

Mr. **Holland**. I do not know how long we can run that contract—we are short of money, too. If we can use the south Florida contract, that will end on September 30, but also in the new legislation, that the President has not signed yet, I believe there is a provision there for proreview.

Mr. **Mica**. For?

Mr. **Holland**. Proreview of HMO's. Proreview or another body to start looking at HMO's—funded by the Government, and I believe that is in the reconciliation bill.

Mr. **Mica**. And let me ask one other question, then I will call on my colleague.

Your statement comes down pretty hard on one group. The rest of the HMO's that you deal with, other than the one mentioned in your statement, you feel are handling the quality assurance, quality issues very well, they are making payment well, the complaints are minimal and so on?

Mr. **Holland**. Yeah, we are doing fine.

Mr. **Mica**. Only one?

Mr. **Holland**. That is right.

Mr. **Mica**. Mr. Boucher.

Mr. **Boucher**. Thank you very much, Mr. Chairman and Mr. Holland, Mr. Galloway, thank you for your testimony this afternoon.

One of the problems that we often hear about in terms of the administration of HMO's is the lag time with regard to both enrollment information processing and disenrollment information processing. That can provide some real anxiety for the participant who does not know whether he is going to be responsible for paying the bill, or whether the HMO is, or whether Medicare is. What progress is being made today to address those problems; has your agency done anything, or are the HMO's doing anything; what kind of progress can you report to us?

Mr. **Holland**. We have had severe problems—about 7 or 8 months ago with the disenrollment/enrollment process, and we put on-line in the regions now an organization called Compu-Serve, we can go online to really speed up the process. It is to the point where if we receive the disenrollment on March 15, we can turn that around within 15 or 20 days. If we receive it after March 15, we can run that in about 30 days. The reason, frankly, that we are still getting a heavy concentration of complaints on enrollment and disenrollment is that we do send out a form automatically now saying that "you are locked in" and this gets lumped under a disenrollment/enrollment complaint, but we are getting a lot more complaints from people who read the lock-in provision that we send them prior to enrolling, than we actually are when we really go through the disenrollment/enrollment complaints.

I am not saying it is completely solved, but I would say the noise level on that one has dropped off tremendously.

Mr. **Mica**. Would the gentleman yield on that?

Mr. **Boucher**. I will be glad to yield.

Mr. **Mica**. On that specific point we uncovered in the hearing 2 years ago a problem with enrollment and disenrollment. From the time you apply to disenroll from an HMO and go back to Medicare, when the papers were filled out, in that interim, you had zero coverage——

Mr. **Holland**. No, it is not——

Mr. **Mica** [continuing]. And then when you enrolled for Medicare, in HMO you had no coverage—there was a gap in coverage; is that correct?

Mr. **Holland**. That is correct. They are not covered. It is either under Medicare or the HMO, but there is no drop in coverage, and the timeframe has dropped rapidly.

Mr. **Boucher**. Well, as I see the problem, though, the participant in the HMO is left at a loss to know who is responsible for the bill, and if the delay is long enough between the time that an application for enrollment or disenrollement is made and that information is entered on the HHS data base, it is very possible that the participant, the patient, is going to get a bill from a health care provider saying, "You are the one who owes us for this service," and I think it is the anxiety that is created from that kind of process that really causes a problem.

Mr. **Holland**. We discussed that this morning. I think that that might be a hole that we are going to have to take a look at. If it runs that long, should we, in fact, put a process in—in other words, a disenrollment problem where it might run 2 months and the person gets an anxiety attack. I think we should look at that, and plus we are going to discuss that when we get back.

Mr. **Boucher**. Well, I am glad to hear progress is being made in that.

I was interesed in the insurance commissioner's information concerning the State requirements for qualifying HMO's in Florida. Is there not some additional Federal security requirement that is imposed to federally quality an HMO, and if there is, can you tell us what that additional security requirement is?

Mr. **Holland**. We insist that they have that system in place that they have now, and also, if I might ask my colleague from Atlanta—Dick, isn't there a bonding provising in there, too, for the tax—if, in fact, one fails——

Mr. **Morris**. No, there is not a bounding provision that I am aware of, for the financial side, unless it is tied in with the Office of Health Maintenance Organization.

Mr. **Mica**. Excuse me. Would you either identify yourself for the record, or——

Mr. **Holland**. This is Mr. Morris, and he is the Division Head in the Atlanta Region for HMO's Medicare/Medicaid, and has the actual program of HMO's.

Mr. **Boucher**. Let me state the question again. That is, is there any Federal security requirement or bonding requirement, in addition to whatever State requirement may be in place, for the Federal qualification of an HMO?

Mr. **Morris**. I am sorry, sir. That is part of the Federal qualification requirements which are imposed by the Office of Health Maintenance Organizations, and once they are certified they have to meet their Federal qualifications, and I believe that is a part of that. We are not at this point directly involved in it, and I really do not have any knowledge of that particular aspect.

Mr. **Boucher**. So I am propounding the question to the wrong witness.

Mr. **Mica**. Let me say at this point, we would like to leave the record open. We will submit questions to your office for answers, and we would like to get the answer to that question, and we will also contact other authorities. I understand our next witness may be able to answer part of that.

Please continue.

Mr. **Boucher**. One additonal question, Mr. Chairman.

Mr. Holland, we have heard in our hearing this morning, and I am sure we are going to hear later during the hearing this afternoon a variety of complaints concerning the operation of at least the IMC HMO in this area. You are familiar with the complaints that have been lodged to date. Based upon your evaluation of those complaints and your knowledge of the total number of enrollees in HMO's in this area, do you think that the complaints that have been lodged are disproportionate in number to the total number of enrollees, or is it about what one could expect given the nature of the operation?

Mr. **Holland**. Three months ago I would have said—or maybe 4 months ago I would have said, "That's probably balanced out," and the last 3 or 4 months it has gone extremely high, and that was one of the concerns we have had, and that is why we have taken a different approach on this. The complaints have skyrocketed.

Mr. **Boucher**. So the complaints are clearly out of proportion to the total number of enrollees?

Mr. **Holland**. We think they are; yes.

Mr. **Boucher**. Have you received any complaints at all with respect to the nine HMO's, that operate in this area, other than IMC?

Mr. **Holland**. I believe—and I am taking this off the top of my head—when I looked at the statistics over the last 6 months, I think we are talking 10, 15.

Mr. **Boucher**. OK; about 10 or 15 complaints——

Mr. **Holland**. Total.

Mr. **Boucher** [continuing]. With regard to the other nine——

Mr. **Holland**. Right.

Mr. **Boucher** [continuing]. And about how many complaints have you had with respect to IMC?

Mr. **Holland**. I would say we are running probably 300, 400 a month, I imagine; it is way out of proportion.

Mr. **Mica**. Let me ask you a question here. You talk about the 50-50 balance. All HMO's and—and correct me if I am wrong—every HMO in the United States that will be participating in this program has 50 percent of the seniors——

Mr. **Holland**. Under the risk contract.

Mr. **Mica** [continuing]. Under the risk contract, has maximum participation—50 percent seniors, and the other 50 percent——

Mr. **Holland**. Commercial.

Mr. **Mica**. Commercial, business employees. IMC is the only one that doesn't meet that criteria?

Mr. **Holland**. No; there are two others in the country that have waivers.

Mr. **Mica**. So, there are three waivers in the United States.

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Mr. HOLLAND. And I made a phone call this morning trying to find out the status on the other two—they are small ones, and I do not think we are having any problems.

Mr. MICA. No problems. So, the only problem is with this.

Mr. HOLLAND. Yeah.

Mr. MICA. You mentioned that you were concerned about reaching a healthy balance which is 50-50. Do you feel that an overabundance, if you will, of seniors in the program is creating any type of financial problems?

Mr. HOLLAND. We look at that from the standpoint—I do not—what we are doing, or attempting to do here, is bring in the financial knowledge and the insurance knowledge, the actuaries and the competitive edge on the 50-percent private to balance out the other side, and here we have had just a continual increase in the Medicare patients without that balance, and we do not think it is healthy.

Mr. MICA. OK. Let me ask you a question.

Mr. HOLLAND. In other words, if IBM wanted to contract with IMC or another one, and they knew there were problems, they would say, "No, we don't want to touch that organization," and we think that is healthy that the commercial side——

Mr. MICA. Both sides.

Mr. HOLLAND [continuing]. With both sides.

Mr. MICA. Well, now they have been striving to reach the 50-percent commercial for how many years?

Mr. HOLLAND. Since we went—let's see, the—well, on the risk contract, we started up what—13 months ago. We are talking what——

Mr. MICA. The waiver has been granted for 2 or 3 years, hasn't it?

Mr. HOLLAND. No. The difference is the contract expires. The present contract with IMC expires in December of this year, but the waiver was granted for 3 years, and the waiver expires in March 1988. At the end of this contract period IMC can go for another year, unless it is not a mutual agreement between the two parties; the Federal Government and IMC.

Mr. MICA. The point that I am trying to get at: They started out, obviously, with almost no commercial and almost all seniors. You said this morning they have gotten up to 27 percent commercial. At the rate they are going, can they make it to the 50 percent required?

Mr. HOLLAND. I hope so. We're going to—let's take a look at it. We've got what—another—what, a year and a half to get up there, March 1988, and I'm sure that they're contacting their subcontractors and pushing enrollment very heavy.

Now if, in fact, they don't make it or something else happens and the contract is terminated, everybody that's enrolled would go back to the regular Medicare fee for service and there would be no break in health care. And then, of course, other HMO's in the area would, obviously, be interested in picking up those members.

Mr. MICA. Well, let me just say this: I know we mentioned this this morning and there was great concern; if they don't reach the 50-50 and you cancel the contract, you say everyone's covered by Medicare, but what we found, I must tell you, before we got

HMO's, is that we couldn't find enough doctors to handle people who went in as Medicare patients.

So, what you see as maybe everybody just going from an HMO to Medicare, I would see as a major crisis frankly, because doctors won't take our seniors just on a Medicare basis.

Mr. **Holland**. Or a very healthy enrollment of other HMO's in the area.

Mr. **Mica**. Or other HMO's in the area. What I would hope we can do is identify the problems in the next few months and correct them, and get them on a course of correction where there are areas of concern, so that we don't get into this situation. As you mentioned this morning, and I must say to the people here today, it is a fact that I was not aware of previously, the Federal Government has no alternative in law but to cancel the contract if they don't meet the terms. And the request was made this morning that we look for some other alternatives to try to give some incentives, some fines, some penalties, and so on, to get HMO's to comply rather that to cancel the contract, which I think would be a very, very difficult situation.

Let me ask you a quick question, then I'm going to dismiss this panel.

With regard to assets and liabilities; I want to pursue this with the IMC people in particular, but can you tell me where you put future services, money held aside for future services in assets or liabilities?

Mr. **Holland**. No, sir; I can't. Again, I have to beg off on that because that's a division we just picked up, the OHMO, and we just picked them up in HCFA last week and now they're part of HCFA and the HMO structure, and I'm really not that familiar with it.

Mr. **Mica**. Let me tell you what I'm really interested in, and we'll submit the questions in writing. I just want to make sure that the cash-flow basis is such—we got ourselves into a situation in the country with Social Security where more was coming out than was going in every year and little by little, the fund that was there to draw on went down to zero and we had to take out of the general revenue. I don't want to see any HMO get into a situation where they're building up debts that are somehow not classified as a liability for future services that they must provide; that is, either getting money in now but they're going to have to give care to people and classify that as some kind of an asset when indeed it's a liability. We 'll talk to IMC about that in a few minutes here, but it's something that we'd like to delve into in some detail.

Any further questions?

Mr. **Boucher**. Nothing.

Mr. **Mica**. We thank you and we appreciate your being with us today.

Our next panel.

HMO representatives: Mr. Robert Wilson, the general manager of the Palm Beach regional office of Av-Med, an HMO; Dr. Jay Sanders, executive vice president for Medical Affairs or IMC, International Medical Centers, which is also an HMO; and I understand that at the last moment we have a third representative of another HMO, CAC—if you'd like to take the desk—it's Mr. Richard Portnoy from CAC, also an HMO.

Mr. **Portnoy**. Thank you.

Mr. **Mica**. Dr. Sanders, if you would like to proceed, and we'll go with you, Mr. Wilson, and Mr. Portnoy, and please feel free to summarize your testimony.

PANEL TWO—HMO REPRESENTATIVES: CONSISTING OF DR. JAY SANDERS, EXECUTIVE VICE PRESIDENT FOR MEDICAL AFFAIRS, INTERNATIONAL MEDICAL CENTERS; ROBERT WILSON, GENERAL MANAGER, PALM BEACH REGIONAL OFFICE, AV-MED HEALTH PLAN; AND RICHARD PORTNOY, CHAIRMAN, PREFERRED RISK SYSTEMS

STATEMENT OF DR. JAY SANDERS

Dr. **Sanders**. My name is Dr. Jay Sanders. I'm executive vice president of medical affairs with International Medical Centers, and I am accompanied this afternoon by Mr. Stephen Cohen, who is executive vice president for financial affairs and the chief financial officer.

We at IMC are aware of the controversy and criticism which surrounds our program. This is an unfortunate but inevitable aspect of a program as new and innovative as ours. We also are aware that our program is being placed under a microscope, and that is as it should be.

We have had our problems and we have made some mistakes, but we have tried to move quickly to resolve them. It is important to keep in mind that IMC's HMO Program is integrated into the traditional health care delivery system within the community, and while this integration, combined with our benefits package, has allowed for rapid growth, we have experienced many of the same kind of problems that are inherent in the fee-for-service health care system; the problems that the Medicare Program, indemnity insurers, and the medical professional community have been struggling with for years.

It is unrealistic to think that any organization, including the Federal Government, can control the action of each individual in its employ or under contract to it. The integrity of any health care system is dependent on the integrity of each individual provider.

What an organization can do, and what we have done, is to provide clear policies and procedure, monitor performance under them, investigate cases of possible violation of rules, and take strong and immediate action against individuals who have been guilty of any misconduct.

While we will probably hear examples, this afternoon, of alleged patient care problems, it should be pointed out, in perspective, that an independent patient satisfaction study, conducted this past September by a researcher at the University of Miami, underlines the overwhelmingly positive response of our members—showing a 92-percent satisfaction rate.

Mr. **Mica**. Dr. Sanders, at this point could I request that you submit that survery and the protocol that's on it for the record?

Dr. **Sanders**. Yes.

While I have prepared a statement which details IMC's experience, in the interest of time, I would like to summarize the specific actions IMC has taken to resolve problems which have arisen, and to assure that we will continue to strive to provide the highest quality medical care to our members.

We have implemented one of the most comprehensive quality assurance systems in the country. It is the only program that utilizes an external audit team to examine patient records within any HMO's private physician's office.

We are implementing a new enrollment audit interview process to ensure better member understanding of our plan and to monitor activities of our marketing people.

We have provided a patient bill of rights to each enrollee that, among other things, clearly indicates that no prescreening to inhibit enrollment can occur.

We have terminated six affiliated centers whose performance did not meet IMC standards.

We have assumed ownership of five affiliated centers because of administrative problems, and taken responsibility for management of another eight centers when our quality assurance program detected problems.

We have improved our toll-free telephone service to our members.

We have referred four cases of possible fraud by individual salesmen to HCFA for prosecution.

We have improved our Medicare grievance process to make it easier for members to request reconsideration.

We have improved our claims systems to ensure that claims cannot be lost.

We have intalled an enhanced automated claims payment system.

We have taken over responsibilities for claims payment for 19 affiliated centers, and we have notified 11 additional affiliated centers of our intent to take over claims payments for them.

These represent but a few of the actions and systems that have been initiated by IMC in an attempt to constantly improve its health care system. There is little doubt that as the system matures other changes will be necessary to ensure the system's integrity.

We stand committed to achieve a standard of care second to none.

Thank you.

[The report submitted by Dr. Sanders follows:]

International Medical Centers HMO

A Federally Qualified
Health Maintenance Organization

Research Report No. 5

of the

Medicare Gold Plus Plan

PATIENT SATISFACTION AT IMC-HMO CENTERS

Prepared by
Richard Langendorf, Ph.D.

Miami, Florida
September, 1985

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLES ii

CHARTS ii

EXECUTIVE SUMMARY iii

PATIENT SATISFACTION: BACKGROUND 1

SATISFACTION AMONG IMC-HMO MEMBERS 2

OVERALL SATISFACTION 2

COMPONENTS OF SATISFACTION 2

PATIENT SATISFACTION: THE IMC-HMO AND FEE FOR SERVICE SYSTEM COMPARED 4

OVERALL SATISFACTION 4

COMPONENTS OF SATISFACTION 5

PATIENT SATISFACTION: TRENDS 6

OVERALL SATISFACTION 6

COMPONENTS OF SATISFACTION 7

DIFFERENCES AMONG AREAS AND TYPES OF CENTERS 8

OVERALL SATISFACTION 8

COMPONENTS OF SATISFACTION 9

ENDNOTES 10

APPENDIX: PATIENT SERVICE SURVEY AND PERCENT DISTRIBUTIONS OF RESPONSES 11

TABLES

No. Title Page

1 OVERALL SATISFACTION WITH SERVICE 2

2 OVERALL SATISFACTION IN THREE TIME PERIODS 6

3 COMPONENTS OF SATISFACTION I THREE TIME PERIODS MEAN SCORES 7

4 OVERALL SATISFACTION WITH SERVICE BY COUNTY AND TYPE OF CENTER 8

5 MEAN SCORES FOR SELECTED COMPONENTS OF SATISFACTION BY COUNTY AND TYPE OF CENTER 9

CHARTS

No. Title Page

1 COMPONENTS OF PATIENT SATISFACTION 2

2 OVERALL SATISFACTION--HMO VS. FEE FOR SERVICE 2

3 COMPONENTS OF SATISFACTION--HMO VS. FEE FOR SERVICE . . 5

EXECUTIVE SUMMARY

This research report examines overall patient satisfaction and the components of satisfaction at wholly owned and affiliated IMC-HMO centers. It is based upon a sample of 4,919 patient visits to centers between January 1984 to April 1985. The data were collected by telephone interviews shortly after the visits. The major findings from this survey follow.

1. Overall satisfaction with services provided at IMC-HMO centers remains very high:

   o eight in ten (80 percent) are very satisfied, and 92.9 percent are either very or somewhat satisfied;

   o just over 5 percent are somewhat or very dissatisfied.

2. In examining the components of satisfaction in more detail:

   o the highest satisfaction is expressed for staff courtesy;

   o the second highest ratings are for items pertaining to the quality and art of care;

   o the lowest ratings are for accessibility and convenience.

3. When patient satisfaction with current IMC-HMO service is compared to the satisfaction expressed by new enrollees with the fee-for-service system prior to their enrolling,

   o IMC-HMO members express greater overall satisfaction with current IMC-HMO medical services than with the services received previously in the fee for service system;

   o IMC-HMO members are also more satisfied with IMC-HMO services than services received previously in the fee for service system across all components of satisfaction.

4. Over time -- that is, when data from early surveys in the first half of 1983 are also included -- there has been a slight decline in overall satisfaction and in most of the various components of satisfaction.

5. There are significant differences among areas and between types of centers with respect to overall satisfaction and the various components of satisfaction.

   - In general, the highest levels of satisfaction are achieved in the affiliated centers in Dade, Broward, and Palm Beach counties;
   - satisfaction in wholly owned IMC-HMO centers fall slightly behind the above three counties;
   - centers in Hillsborough and Pasco counties fall below the above referenced areas with respect to overall satisfaction, but are similar with respect to many of the specific components of satisfaction;
   - patients at the centers in Pinellas county, on average, express the least satisfaction, both in terms of overall satisfaction and the individual components of satisfaction;
   - it should be noted, though, that the above characterizations reflect averages when centers are grouped together, and that individual centers within each group may vary considerably in the satisfaction they provide their patients.

PATIENT SATISFACTION

BACKGROUND

Patient satisfaction with health and medical care service has received increasing attention for more than a decade. Aside from health status, patient satisfaction is perhaps the most commonly measured outcome in the evaluation of health care.[1] This emphasis upon patient satisfaction recognizes the importance of patient-identified problems both to health policy making and to those managers seeking to monitor and improve the quality of services they provide. In addition to reflecting past experience with the health care system, patient satisfaction is of interest because it may influence future behavior, such as timeliness of care seeking or service provider switching.[2]

Recent reviews of the literature of patient satisfaction have concluded the following:

- o that although satisfaction responses may be shaped by actual experience, as well as by expectations, preferences, and cathexis, responses are most sensitive to the actual patient experience and can be valid indicators of system performance;

- o that the use of a survey approach with standardized questionnaire items is a cost-effective and reliable method of data collection about patient satisfaction;
- o satisfaction is a "multi-dimensional" concept, and it is therefore useful to separate out the various aspects of satisfaction.[3]

This study of patient satisfaction utilizes a survey approach with standardized questionnaire items. Patients are selected to participate in the survey based upon a random sample of time periods for each Center. Those patients that enter a center during a sample period are notified that they will be called and interviewed within a few days. Interviewing is done by telephone from a central facility. The following analysis is based primarily upon a sample of about 4,919 patient visits. The analysis of trends in patient satisfaction divides this sample into two time periods -- January through July 1984 and August 1984 to April 1985 -- and adds data from 2,009 patient visits between February and June 1983.

SATISFACTION AMONG IMC-HMO MEMBERS

OVERALL SATISFACTION

The survey indicates a high level of satisfaction with service. Eight in ten responded that they were very satisfied, and about 93 percent indicated that they were either very satisfied or somewhat satisfied. The table below summarizes these findings.

TABLE 1: OVERALL SATISFACTION WITH SERVICE

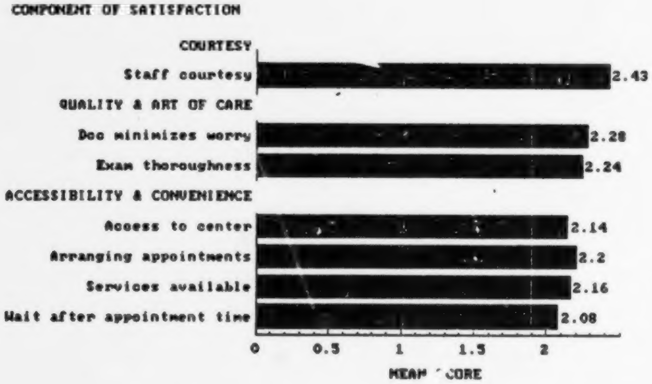
How satisfied are you overall with the medical care you received?

	Number	Percent	Cumulative Percent
Very satisfied	3822	80.0	80.0
Somewhat satisfied	617	12.9	92.9
Neutral	87	1.8	94.7
Somewhat dissatisfied	172	3.6	98.3
Very dissatisfied	80	1.7	100.0

COMPONENTS OF SATISFACTION

The highest satisfaction was expressed for staff courtesy. The next highest were for items pertaining to the quality and art of care. The lowest satisfaction related to accessibility and convenience of care. The most frequent problem appears to be the amount of time a patient waits, after the scheduled appointment time, to see the physician.

CHART 1: COMPONENTS OF PATIENT SATISFACTION



Note: The mean score is computed based upon the following assigned values -- excellent = 3, good = 2, fair = 1, and poor = -2.

PATIENT SATISFACTION: THE IMC-HMO AND FEE FOR SERVICE SYSTEM COMPARED

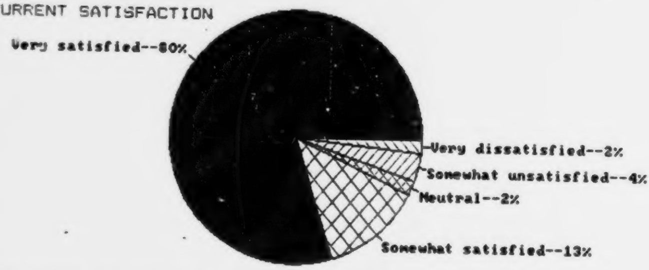
The enrollment survey provides an evaluation of patient satisfaction with the fee for service system, the system utilized by IMC-HMO members before joining. The survey of members using IMC services provides an evaluation of their satisfaction with the services provided by the HMO. A comparison of these two service delivery systems, in terms of HMO member's evaluations, is possible as the same questions were asked in both interviews.

OVERALL SATISFACTION

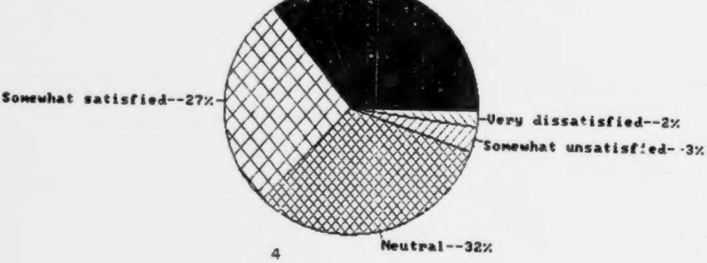
While respondents expressed little direct dissatisfaction with either the HMO or fee for service medical care, there was much higher satisfaction expressed for the HMO. This is clearly indicated in the following chart.

CHART 2: OVERALL SATISFACTION--HMO VS. FEE FOR SERVICE

IMC-HMO: CURRENT SATISFACTION



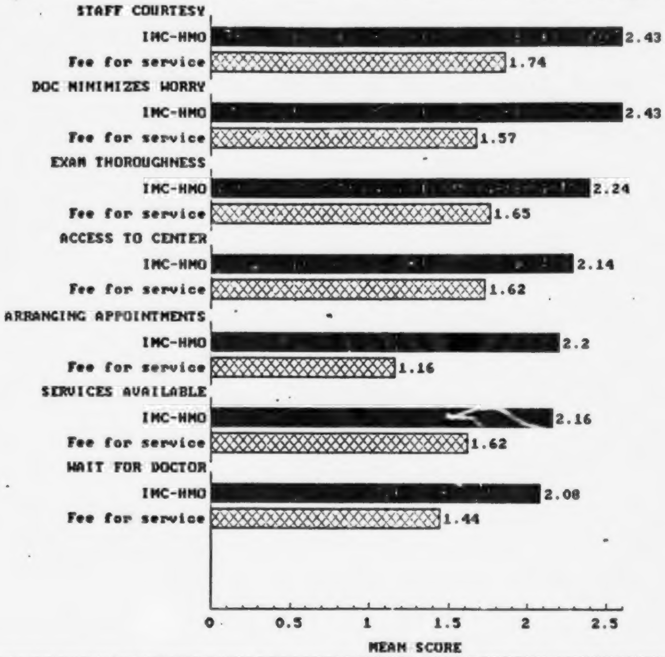
SATISFACTION PRIOR TO JOINING
(FEE FOR SERVICE)



COMPONENTS OF SATISFACTION

The satisfaction of patients with IMC-HMO services is clearly greater than their satisfaction with the services they received in the fee for service system before they joined. This greater satisfaction occurs across all components that are compared directly. This pattern is clearly revealed on the chart that follows.

CHART 3: COMPONENTS OF SATISFACTION--HMO VS. FEE FOR SERVICE



Note: The mean score is computed based upon the following assigned values -- excellent = 3, good = 2, fair = 1, and poor = -2.

PATIENT SATISFACTION: TRENDS

For this examination of trends in patient satisfaction, patient interviews have been grouped into three time periods: February through May 1983, January through July 1984, and August 1984 to April 1985.

OVERALL SATISFACTION

Throughout the life of the IMC-HMO program overall satisfaction with medical care has remained high, with over 90 percent saying they were either very of somewhat satisfied in all three time periods. The mean scores reflect a slight decline, though, due primarily to near tripling in those dissatisfied, though these remain a very small fraction of the patient population.

TABLE 2: OVERALL SATISFACTION IN THREE TIME PERIODS

HOW SATISFIED WERE YOU OVERALL WITH THE MEDICAL CARE YOU RECEIVED?

		COMPARISON PERIODS*		
		1	2	3
Percent				
Very Satisfied	(3)	81.5	79.9	80.2
Somewhat Satisfied	(1)	13.1	14.7	11.8
Neutral	(0)	3.1	1.5	2.1
Somewhat Dissatisfied	(-1)	1.6	3.1	3.7
Very Dissatisfied	(-3)	.8	.8	2.3
MEAN score		2.54	2.49	2.42

* Comparison Periods:
1. February through May, 1983
2. January through July, 1984
3. August through April, 1985

COMPONENTS OF SATISFACTION

In examining the various components of satisfaction across the three time periods, very little change is observed. With the exception of waiting for the doctor after the scheduled appointment time, where a slight improvement is registered, there tends to be a very slight decline in satisfaction over time. However the extent of change is very small. It is probably best to view the situation is relatively unchanging. The table below displays these findings.

TABLE 3: COMPONENTS OF SATISFACTION IN THREE TIME PERIODS
MEAN SCORES**

Based on your experience with IMC-HMO, would you evaluate each of the following aspects of medical care that you received as excellent, good, fair, or poor?

COMPONENT OF SATISFACTION	COMPARISON PERIODS*		
	1	2	3
COURTESY			
Staff courtesy	2.53	2.52	2.38
QUALITY AND ART OF CARE			
Physician minimizes worry	2.35	2.38	2.22
Thoroughness and carefulness of exam	2.38	2.28	2.22
ACCESSIBILITY AND CONVENIENCE			
Getting to center	2.32	2.07	2.18
Arranging appointments	2.18	2.18	2.21
Services and facilities available	2.26	2.21	2.13
Wait for doctor after appointment time	1.84	2.02	2.13

Notes:

* Comparison Periods:
1. February through May, 1983
2. January through July, 1984
3. August through April, 1985

** Mean score computed based upon following assigned values for period 1 -- excellent = 3, good = 2, fair = 1, poor = -2. For periods 2 and 3 a response of "no opinion" = 0 is included. Fewer that 1 percent of respondents claimed no opinion, so this has no significant impact on these results.

DIFFERENCES AMONG AREAS AND TYPES OF CENTERS

For these analysis a distinction is made between IMC wholly owned centers and affiliated centers. The affiliated centers are further divided by county.

OVERALL SATISFACTION

There are some significant differences among areas in overall satisfaction. If one looks at either the percent very satisfied, or the summary mean scores, the affiliated centers in Dade, Palm Beach, and Broward Counties rank highest, with IMC wholly owned centers following closely behind. Lower levels of satisfaction are registered in the three Tampa Bay area Counties, Hillsborough, Pasco, and Pinellas. The table below summarizes these findings.

TABLE 4: OVERALL SATISFACTION WITH SERVICE BY COUNTY AND TYPE OF CENTER

	IMC	AFFILIATED CENTERS					
		Dade	Broward	Palm Beach	Hillsborough	Pasco	Pinellas
PERCENT DISTRIBUTION							
Very satisfied	83.9	89.2	84.9	87.3	68.3	59.9	61.7
Somewhat satisfied	7.5	8.6	10.4	9.1	24.4	32.7	20.1
Neutral	2.5	1.1	1.7	.2	1.4	7.3	2.4
Somewhat dissat.	3.8	.7	2.4	2.2	3.6	0.0	11.4
Very dissatisfied	2.4	.4	.7	1.2	2.3	0.0	4.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
MEAN SCORE*	2.48	2.74	2.61	2.65	2.19	2.13	1.80

* Note: Mean score computed based upon following assigned values -- 3 = very satisfied, 1 = Somewhat satisfied, 0 = neutral, -1 = somewhat dissatisfied, and -3 = very dissatisfied.

COMPONENTS OF SATISFACTION

In examining the components of satisfaction, the same general pattern prevails in all areas -- that is, courtesy is ranked highest, the quality and art of care next, and accessibility and convenience is ranked lowest.

The differences among areas follow a similar pattern to that found with overall satisfaction. In general, the affiliated centers in Dade, Palm Beach, and Broward rank highest, followed closely by the IMC wholly owned centers. Pasco County also ranks in this top group though. Hillsborough ranks along with the top group on items of courtesy and quality and art of care, but evidences problems in accessibility and convenience. Pinellas ranks lower than the others across all categories. The table below summarizes these findings. Again it should be noted that these are average scores within the areas, and they may conceal considerable variation among individual centers within each area.

TABLE 5: MEAN SCORES* FOR SELECTED COMPONENTS OF SATISFACTION BY COUNTY AND TYPE OF CENTER

Based on your experience with IMC-HMO, would you evaluate each of the following aspects of medical care that you received as excellent, good, fair, or poor?

COMPONENT OF SATISFACTION	IMC	AFFILIATED CENTERS					
		Dade	Broward	Palm Beach	Hillsborough	Pasco	Pinellas
COURTESY							
Staff courtesy	2.43	2.55	2.48	2.50	2.40	2.51	2.16
QUALITY & ART OF CARE							
Doc minimize worry	2.30	2.37	2.30	2.28	2.28	2.36	2.12
Thorough exam	2.30	2.32	2.29	2.27	2.29	2.15	1.93
ACCESSIBILITY & CONVENIENCE							
Getting to center	2.22	2.16	2.13	2.20	1.96	2.33	1.95
Arranging app'ts.	2.19	2.35	2.24	2.24	2.16	2.27	1.96
Services available	2.16	2.27	2.22	2.20	2.42	2.30	1.73
Wait for doctor	2.12	2.23	2.15	2.17	1.31	2.33	1.74

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* Note: Mean score computed based upon following assigned values -- excellent = 3, good = 2, fair = 1, poor = -2.

ENDNOTES

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1. Cf., for example, Brook, Robert Patient Satisfaction with Medical Care. (Issue Paper No. 2, unpublished manuscript) Los Angeles, Calif.: University of California at Los Angeles, no date.

2. Among the numerous studies finding significant relationships between patient satisfaction and medically relevant behavior are, for example, Bashshur, R. L. et. al. "Consumer Satisfaction with Group Practice: The Cha Case" American Journal of Public Health. 1967,57, pp. 1991-1999; Becker, M.H., Drachman, R.H. and Kirscht, J.P. "A New Approach to Explaining Sick-role Behavior in Low-Income Populations" American Journal of Public Health. 1974, 64, pp. 205-216; Aday, L.A. "Economic and Non-economic Barriers to the Use of Needed Medical Services" Medical Care. 1975, 13, pp. 447-456.

3. This work has drawn heavily upon the review of the literature by John Ware Jr., Allyson Davies-Avery, and Anita L. Stewart. "The Measurement and Meaning of Patient Satisfaction: A Review of the Literature". Health Medical Care Services Review. January/February 1978, 1/1, pp. 1-15.

APPENDIX:
PATIENT SERVICE SURVEY AND PERCENT DISTRIBUTIONS OF RESPONSES

PLEASE ANSWER ALL QUESTIONS FOR YOUR LAST VISIT ONLY

1. How did you get to the center?

Walk	3.5%
Public bus	4.1
Drive self	54.4
Taxi	.4
Ride with friend or relative	32.0
IMC-HMO bus	4.2
Other	1.3

2. About how long did it take you to get to the center? (Note: responses grouped during analysis.)

5 minutes or less	10.6
6 through 15 minutes	61.9
16 through 30 minutes	24.2
31 through 45 minutes	2.0
more than 45 minutes	1.4

3. How long in advance was this visit scheduled? (Note: Responses grouped during analysis.)

Came in without an appointment.	7.1
Same day as made appointment	2.9
Number of days in advance	
1 thru 6 days	16.5
7 thru 14 days	38.2
15 thru 30 days	23.2
more than 30 days	12.2

4. Who requested this visit?

Your physician	48.0
Yourself (the patient)	50.4
Other	1.6

5. How many times, if any, did you attempt to telephone for an appointment?

Did not attempt to telephone	9.1
Number of telephone calls	
one	85.7
two	2.9
3 or more	2.3

Note: Questions 6, 7, and 8 were asked as follows:

6. At what time did you arrive at the center?

7. At what time was your scheduled appointment?

8. At what time did you see your doctor or medical person?

The answers to these questions were used to compute the following waiting times:

For those with scheduled appointments

Arrival before scheduled appointment

0 through 5 minutes	25.4
6 through 15	36.6
16 through 30	22.6
31 through 60	10.8
61 through 90	3.1
more than 90	1.4

Wait after scheduled appointment to see doctor

0 through 5 minutes	37.7
6 through 15	29.6
16 through 30	20.1
31 through 60	8.9
61 through 90	1.7
more than 90	2.0

For all patients

Elapsed time between arrival and seeing doctor

0 through 5 minutes	5.6
6 through 15	24.9
16 through 30	40.3
31 through 60	22.6
61 through 90	3.0
more than 90	3.6

9. Did you have a preference for the medical person you saw?

No preference	55.0
Yes, preference	
saw person desired	42.3
did not see desired person.	2.7

10. What speciality or department did you visit? (Check all that apply.)

Primary care physician	82.5
Specialist	
angiology	1.3
cardiology	3.4
dermatology	1.3
opthalmology	1.9
podiatry	1.8
orthopedist	1.0
all others	less than 1.0
nursing service	5.1
x-ray department	4.6
laboratory	15.3
EKG department	5.3
physical therapy	.8
other	2.8

11. How much time did the physician or other medical person(s) spend with you?
(Note: responses grouped during analysis.)

0 through 5 minutes	2.4
6 through 10	7.4
11 through 15	51.5
16 through 20	21.8
21 through 30	10.6
more than 30	6.4

12. Was this your first visit to the center?

Yes, first visit	7.8
No, not first visit	92.2

13. What was the main medical problem or condition for which this visit was made?
(Check only one.)

Chronic condition	
regular treatment	10.1
flare-up or attack	2.6
Injury	1.1
Routine physical examination	7.9
Symptom, illness, or other condition	62.1
Post-hospitalization visit	1.0
Prescription refill	3.0
Other	12.1

14. With regard to this medical problem or condition what kind of visit was this?

First visit	22.7
Follow-up	77.3

15. Based on your experience with IMC-HMO, would you evaluate each of the following aspects of medical care you received as excellent, good fair, or poor?

	Excel-lent	Good	Fair	No Opin.	Poor
a. Ease of getting to your usual place of medical care from where you live? ...	30.4	60.3	6.7	.2	2.4
b. The availability to you of all the medical services and facilities you need?	33.7	55.6	8.0	.6	2.1
c. Ease of calling or arranging for an appointment?	32.9	59.2	5.7	.5	1.6
d. Amount of time spent waiting to see a medical person after your appointment time?	30.8	55.9	10.2	0.0	3.1
e. Your ability to see a medical person as soon as you would like?	31.8	57.0	7.2	1.4	2.7
f. Courtesy and consideration of staff?	53.5	40.4	4.7	0.0	1.3
g. Amount of personal interest shown by the doctor or other medical persons?	42.8	48.5	7.0	.2	1.5
h. The willingness of the medical staff to discuss and explain your medical problems?	39.8	50.5	6.7	.8	2.2
i. The nurse's attitude and treatment?	53.1	41.6	4.1	.2	1.0
j. The receptionist's attitude and treatment?	52.1	42.6	4.2	0.0	1.0

ANSWER THE NEXT TWO QUESTIONS ONLY IF YOU SAW A PHYSICIAN.

	Excel-lent	Good	Fair	No Opin.	Poor
k. Effort by the physician to do his or her best to keep you from worrying unnecessarily?	40.2	51.8	6.1	.8	1.1
l. If examination needed, the carefulness and thoroughness of the physician in checking everything when examining you?	38.4	52.5	6.7	.9	1.4

16. How satisfied are you, overall, with the medical care you received?

Very satisfied	80.0
Somewhat satisfied	12.9
Neutral	1.8
Somewhat dissatisfied	3.6
Very dissatisfied	1.7

17. On this visit, did the doctor or other medical person:

	Percent yes
a. Perform or order any diagnostic procedures (such as lab tests, x-rays, Pap smear..)	34.7
b. Examine you	90.4
c. Write a prescription	75.9
d. Give or order any vaccinations or immunizations	1.4
e. Perform any surgical procedure	1.3
f. Provide or order some treatment	9.9
g. Explain what the problem or condition was or give an opinion on your health condition	73.6
h. Give any advice or instructions	80.2
i. Offer reassurance and understanding	85.7
j. Discuss any problems relating to family or your personal situation	3.5
k. Refer you to another doctor	8.0
l. Tell you to make a return visit	77.5

18. Associated with this visit, did you experience any problem that caused you concern or inconvenience?

No	94.1
Yes,	
did not discuss with staff	2.9
discussed and	
satisfied with outcome of discussion	.9
not satisfied with outcome of discussion	2.2

The following includes some basic demographic information on respondents that was obtained through merging these survey data with IMC-HMO administrative data.

Age	
less than 55	1.5
55 through 64	4.6
65 through 69	24.1
70 through 74	30.9
75 through 84	33.9
85 and older	4.9

Sex	
Male	45.9
Female	54.1

Language preference	
English	94.6
Spanish	5.4

PATIENT SATISFACTION AT IMC-HMO CENTERS:
A CHART SUMMARY

Research Report No. 5

Prepared By
Richard Langendorf, Ph.D.

Miami, Florida
September, 1985

CHART 1

OVERALL SATISFACTION WITH SERVICES PROVIDED AT IMC-HMO CENTERS REMAINS VERY HIGH, WITH EIGHT IN TEN (80 PERCENT) VERY SATISFIED, AND 92.9 PERCENT ARE EITHER VERY OR SOMEWHAT SATISFIED.

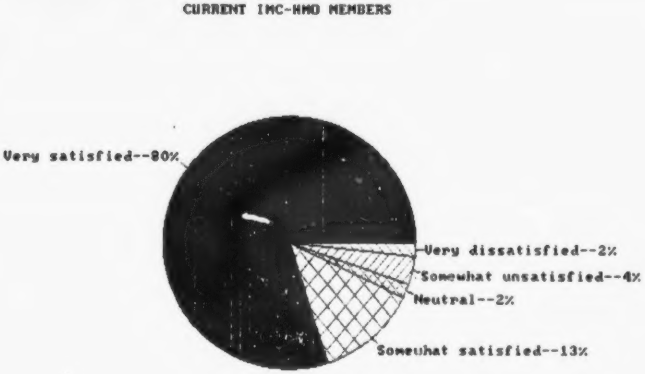
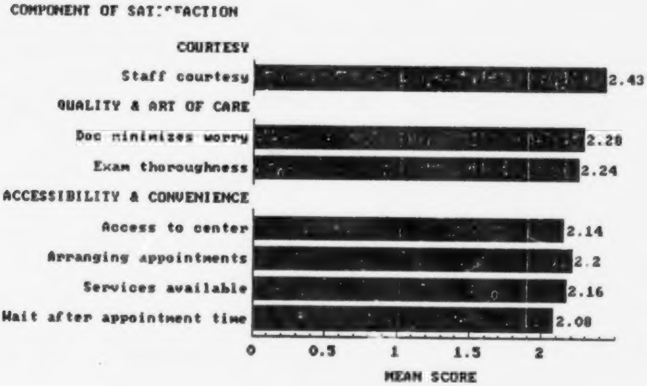


CHART 2

IN EXAMINING THE COMPONENTS OF SATISFACTION IN MORE DETAIL:

- THE HIGHEST SATISFACTION IS EXPRESSED FOR STAFF COURTESY;
- THE SECOND HIGHEST RATINGS ARE FOR ITEMS PERTAINING TO THE QUALITY AND ART OF CARE;
- THE LOWEST RATINGS ARE FOR ACCESSIBILITY AND CONVENIENCE.



Note: The mean score is computed based upon the following assigned values -- excellent = 3, good = 2, fair = 1, and poor = -2.

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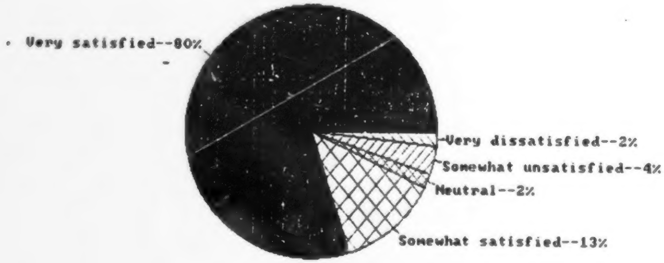
CHART 3

WHEN PATIENT SATISFACTION WITH CURRENT IMC-HMO SERVICE IS COMPARED TO THE SATISFACTION EXPRESSED BY NEW ENROLLEES WITH THE FEE-FOR-SERVICE SYSTEM PRIOR TO THEIR ENROLLING, IMC-HMO MEMBERS EXPRESS GREATER OVERALL SATISFACTION WITH CURRENT IMC-HMO MEDICAL SERVICES THAN WITH THE SERVICES RECEIVED PREVIOUSLY IN THE FEE FOR SERVICE SYSTEM.

CURRENT SATISFACTION (IMC-HMO)



SATISFACTION PRIOR TO JOINING
(FEE-FOR-SERVICE SYSTEM)

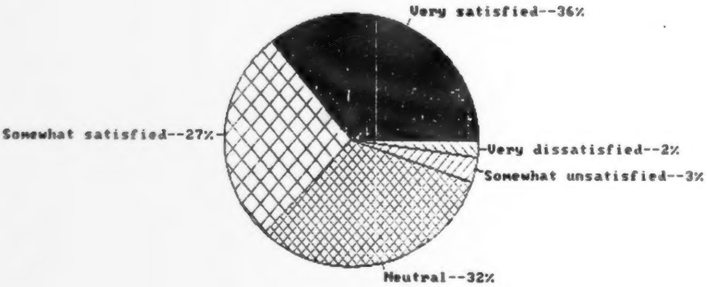
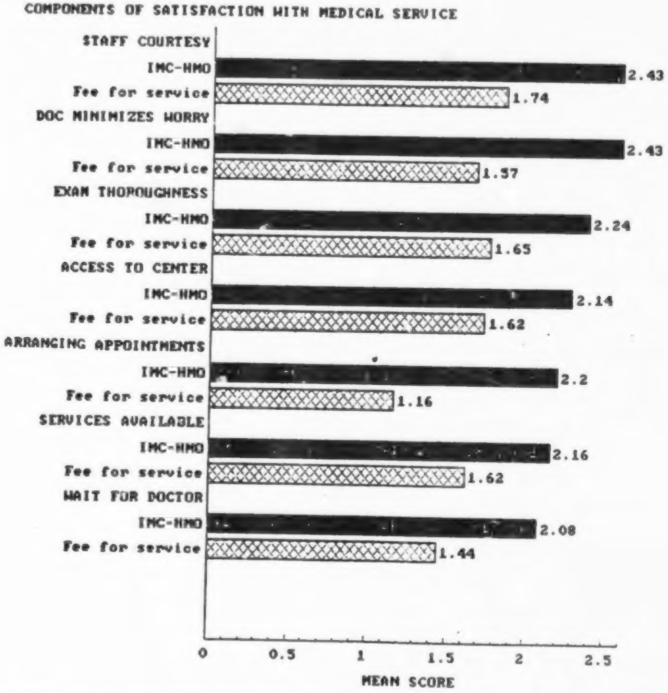


CHART 4

IMC-HMO MEMBERS ARE ALSO MORE SATISFIED WITH IMC-HMO SERVICES THAN SERVICES RECEIVED PREVIOUSLY IN THE FEE FOR SERVICE SYSTEM ACROSS ALL COMPONENTS OF SATISFACTION.



Note: The mean score is computed based upon the following assigned values -- excellent = 3, good = 2, fair = 1, and poor = -2.

CHART 5

OVER TIME -- THAT IS, WHEN DATA FROM EARLY SURVEYS IN THE FIRST HALF OF 1983 ARE ALSO INCLUDED -- THERE HAS BEEN A SLIGHT, ALMOST NEGLIGIBLE DECLINE IN OVERALL SATISFACTION.

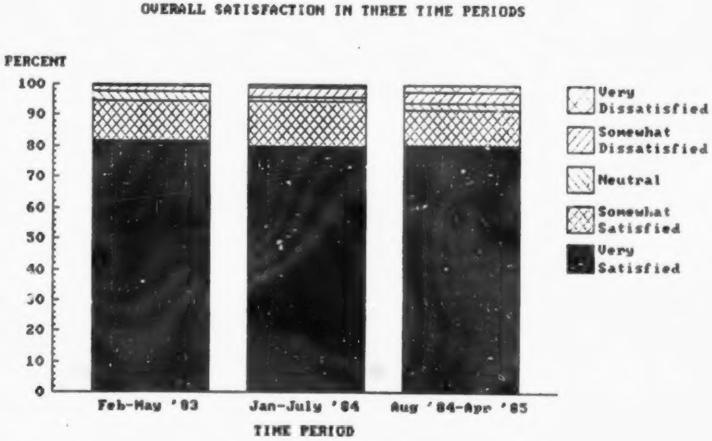
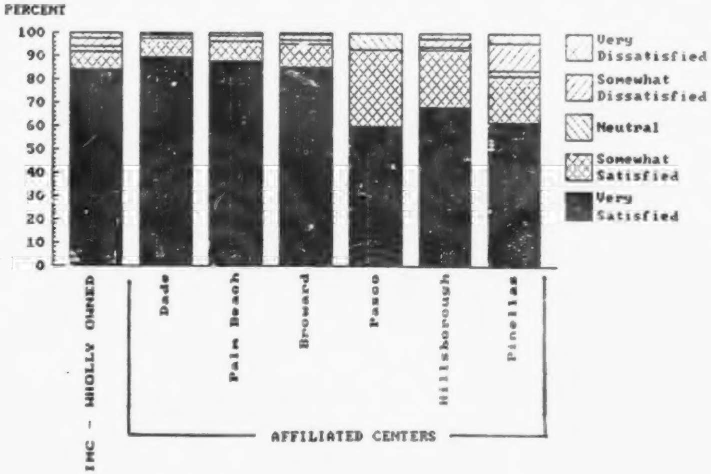


CHART 6

THERE ARE SIGNIFICANT DIFFERENCES AMONG AREAS AND BETWEEN TYPES OF CENTERS WITH RESPECT TO OVERALL SATISFACTION.

- IN GENERAL, THE HIGHEST LEVELS OF SATISFACTION ARE ACHIEVED IN THE AFFILIATED CENTERS IN DADE, BROWARD, AND PALM BEACH COUNTIES;
- SATISFACTION IN WHOLLY OWNED IMC-HMO CENTERS FALL SLIGHTLY BEHIND THE ABOVE THREE COUNTIES;
- CENTERS IN HILLSBOROUGH AND PASCO COUNTIES FALL BELOW THE ABOVE REFERENCED AREAS;
- PATIENTS AT THE CENTERS IN PINELLAS COUNTY, ON AVERAGE, EXPRESS THE LEAST SATISFACTION;
- IT SHOULD BE NOTED, THOUGH, THAT THE ABOVE CHARACTERIZATIONS REFLECT AVERAGES WHEN CENTERS ARE GROUPED TOGETHER, AND THAT INDIVIDUAL CENTERS WITHIN EACH GROUP MAY VARY CONSIDERABLY IN THE SATISFACTION THEY PROVIDE THEIR PATIENTS.

OVERALL SATISFACTION: CENTER GROUPINGS



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Mr. MICA. Thank you.

Mr. Wilson, and I'd like to ask Congressman Boucher to chair for just a minute; I'll be right back. Please continue.

Mr. BOUCHER. Mr. Wilson, go right ahead.

Mr. WILSON. Thank you.

STATEMENT OF ROBERT WILSON

Mr. WILSON. Mr Boucher, my name is Robert Wilson, and I'm the general manager of the Palm Beach regional office for the Av-Med Health Plan, which covers Palm Beach County and the northern part of Broward County.

The Av-Med Health Plan is one of the oldest and largest in Florida. At the present time, we have over 105,000 members; although, our Medicare enrollment is low, only around 6,000, and in the North Broward area we have about 584 Medicare participants, and in Palm Beach County we only have about 182. So we have—most of our Medicare participation is in Dade County rather than Palm Beach or Broward.

The problems that the Congressman identified in a survey that he did—and I'd like to commend him and his staff for doing that survey. Basically there were four. One is not able to care for seriously ill patients; the exaggerated claims on services and benefits by the health maintenance organizations; third, inefficient reimbursement procedures; and, fourth, inadequate referrals to hospitals. I'd like to just briefly comment on each of those areas.

In terms of the exaggerated claims for services and benefits, we have a marketing program which has been developed in conjunction with the representatives in region IV. We have a very definite enrollment process and marketing material. Our enrollment personnel are instructed to go by the book in terms of what they tell respective enrollees. When we get an initial call by a prospective member, they are queried as to whether or not they're familiar with the HMO program. Following the mail-out of material and then the follow-up call, then an application is returned to us so that the individual is fully aware as to what they could expect in terms of the participation in the program.

We have had some disenrollment problems, which have been mentioned before, and I think that those are being addressed.

The Av-Med Health Plan is a little different than the International Medical Center's program in that we are an independent practice association model, which means that we contract with private physicians in the community to provide services to our members in their office, just as they would any other private patient. At the present time, in the three-county area, of Dade, Broward, and Palm Beach County, we have over 2,000 physicians under contract of which one-third are considered primary care physicians and two-thirds are considered specialists.

We rely quite heavily on the primary care physician as the "gate-keeper" concept in terms of medical care, and every member that joins our program must select a primary care physician, who then becomes responsible for directing and managing the medical services that that member needs.

I might mention that every physician that belongs to our program must have staff privileges in at least one hospital in the area which he services.

We also have a very extensive hospital network in the three-county area. We have over 40 hospitals under contract, both full-service and specialty care facilities. In addition to physicians and hospitals, we contract with ancillary services, such as home health agencies, nursing homes, physical therapy, ambulatory surgery, cardiac diagnostic services, and other medical care programs that is needed by the members.

In terms, the problems area, identified in the survey, relating to claims processing, I think, has been discussed very extensively. I might just mention that we—the basic problems that we run into in terms of processing claims is that there is either missing information or the wrong information; second, that a lot of claims are not appropriate to us in terms of our responsibility, such as automobile accidents.

Another major problem is the coordination of benefits and determining who is the primary payer; who is primarily responsible for paying that claim.

This, of course, delays the payment of claims, and sometimes results in members getting dunning bills from providers, or claims turned over to collection agencies. I will say that if we do get a clean claim in our program, we are able to pay that within 4 weeks. We do have a complaint grievance procedure which I submitted for the record.

We are constantly looking at ways in which we can improve the operation of our program. I was just recently given this new brochure, that's being mailed out to all of our members, which identified three Av-Med rules that people should follow in terms of their participation in our program.

Number one rule is always identify yourself as an Av-Med member. The second rule is always call your primary care physician first whenever you need medical attention, and, third, always feel free to call Av-Med if you have any problem, question, or complaint.

These are being mailed out to all of our members in an attempt to help educate them in terms of utilizing the health maintenance organizational system that we have developed.

We need to consider that a health maintenance organization is a relatively new concept in South Florida. There is still a lot of misunderstanding as to how a health maintenance organization works. It is extremely difficult for a lot of people to break their old habits that they've had in terms of seeking medical care. I think many times there is a communication problem between the members and the providers, and there are different levels of expectations that arise—both by the members and the providers. And I think there is a need for a continual educational program, not only by the health maintenance organizations themselves, but also by other outside organizations to increase the knowledge and understanding of the citizens of this area in terms of the health care delivery system.

Thank you.

Mr. BOUCHER. Mr. Portnoy?

Mr. PORTNOY. Thank you.

STATEMENT OF RICHARD PORTNOY

Mr. PORTNOY. My name is Richard Portnoy. I am the chairman of the company called Preferred Risk Systems. We are a management service provider to CAC, Comprehensive American Care, in this geographical location.

I am speaking today as a management service provider for Preferred Risk Systems, and will be able to answer your questions with respect to how we work it in this geographical location, and any other questions that you would care to ask with respect to CAC, the umbrella organization.

My organization was born at the request of the private practice physicians in this area. These were physicians who did not want to, for whatever reason, become associated with a corporate type of HMO entity, in the sense that the primary care physicians that are a member of our plan, and are contracted with CAC, are regulated by CAC with regard to the quality assurance and the health care delivery system that they provide, but these private physicians, through our company, Preferred Risk Systems, make arrangements locally that all bills are paid, that the money that is given from the Federal Government through CAC—the Part B money, approximately $77—the primary care physician in this geographic location does not get all that money, he only gets $43 of it. The rest of it goes into an escrow account to pay for specialist bills, as they arise, on a monthly basis.

The specialists in this geographical location send the bills to my office, not to the physician; my office is in Coral Springs on Sample Road. We pay those bills from the 15th to the 20th of every single month.

The private practice physicians here finally saw the advantages of the health maintenance legislation; the fact that quality care, in fact, can be given, and they have eliminated, by themselves, the financial interest or the scintilla of the motive of the financial interest not to treat. We have given the primary care physician the $43. The balance of the Part-B money goes to pay the specialist. Almost every single private practice specialist, to a tee, in this community will see patients on this program because they're paid almost, to a tee, on a fee-for-service basis. We pay almost all of our specialists a Medicare-assignment figure. There is plenty of money in this program to provide health care to the primary physician or specialists in the hospitals.

My company makes its money two ways. We get a marketing fee from CAC for every person that enrolls—a one-time fee. The physicians in this community have agreed to give us the Part-A risk, the hospital risk, so that no physician has a financial interest when he puts somebody in the hospital or when he has that person in the hospital discharged. These are very, very important differences, very, very important motivations in the administering of the health care.

In all of the other facilities or situations, it would appear that all of the money goes to one facility. What we have done here is that we have split it up.

My suggestion to this panel, and I think that suggestion has been alluded to so far in the testimony, is that: No. 1, for any subcontractor or any affiliated provider, it should not be permitted to be owned by a businessman—when he hires physicians, pays the physicians a salary, the businessman is taking money out of that center that should be going to health medical care.

In our organization, and in the CAC organization, there is no facility that is permitted to be owned by a businessman. It's owned by a physician and the physician who treats—a very, very important factor.

I think that some of the problems that have presently been existing in south Florida—and these problems are always the same; nonpayment of bills, hospitals won't admit, and the reason why we have these problems is because there are businessmen involved in the subcontracting or the affiliated provider situations, and there is no provision in the Federal legislation, at all, that says how much that businessman should be able to make a month, nor does it say anywhere in the legislation, to my knowledge, how much a physician who owns a facility that's in practice should be making a month.

The need for the services arise, and bills don't come in for 60 to 90 days—perhaps in those individual situations, the time that the charges are actually due, there is no money to pay for them. There is no reason for that to happen. There is no reason for the financial integrity of any health maintenance organization to be in doubt. As long as it is the physicians who are receiving the money, those physicians are the same physicians that are supplying the health care, and the profit and loss from the hospital fund are taken out of the physicians' hands.

Thank you.

Mr. MICA. Thank you.

Let me ask you a quick question. How many patients do you have in Broward County; how may enrollees?

Mr. PORTNOY. My geographical location under the CAC is—we have 12 primary care physicians contracted to us and to CAC. We have now 3,000 members. We have been enrolling people in Broward County, under CAC, my company, Preferred Risk, for approximately 7 months. We are growing now at a rate of 500 per month, and some people tell me that that's an astounding growth rate.

Most of the people that join our organization, join our organization because it's private practice physicians.

Mr. MICA. You have 3,000 members.

Mr. PORTNOY. That's correct.

Mr. MICA. Can you tell me how much you have outstanding, over 60 days, that you owe physicians?

Mr. PORTNOY. None.

Mr. MICA. How about you, Mr. Wilson?

Mr. WILSON. I don't know, sir. I don't have that financial information.

Mr. MICA. Can you hazard a guess within reason?

Mr. WILSON. No, sir, I can't; I can find out for you, though.

Mr. MICA. Dr. Sanders?

Dr. SANDERS. I would defer to Mr. Cohen.

Mr. MICA. Mr. Cohen?

Mr. COHEN. Could you repeat that, please?

Mr. MICA. Can you give me an idea of how much you have outstanding, owed to physicians, owed for services, overdue 60 days?

Mr. COHEN. I couldn't give you that amount just here.

Mr. MICA. Can you provide that for the record?

Mr. COHEN. Oh, sure. Surely.

Mr. MICA. Can you, Mr. Wilson?

Mr. WILSON. Yes, sir.

Mr. MICA. And you have none.

How many patients do you have in Broward County; enrollees?

Dr. SANDERS. I believe approximately 35,000, but I can give you the specific figures in 1 second.

Mr. MICA. Approximately 35,000.

Dr. SANDERS. Yes.

Mr. MICA. Mr. Wilson, are you in Palm Beach or just——

Mr. WILSON. Yes. We have—as I mentioned while you were out of the room, sir—at the time, in your District, south Palm Beach and North Broward, we have only 766 Medicare beneficiaries as members of our program. The rest of them—we have a total of approximately 6,000 or so Medicare beneficiaries in our total program, including Dade, Broward, and Palm Beach Counties—out of 105,000 total membership.

Mr. MICA. Now, Mr. Portnoy, are you indicating that you feel there should be legislation to limit the amount of profit that any HMO can make?

Mr. PORTNOY. I am not saying that there should be a limit as to the profit that an HMO makes. What I'm saying is that I get a little confused when a businessman hires a physician and is making profit from the delivery of health care on that kind of basis.

I think that the amount of money that's taken out in those situations, if it was not taken out, there would be no problems with this system. There would be not problems from a financial standpoint.

I think if you check through your records of those affiliated providers or organizations throughout the United States that have perhaps gotten into some financial insolvency, you will find that it was a businessman that had hired the physicians and was paying them on a salary. When the physician then refers them out to another specialist or to another physician, it's still the businessman that has to pay the bill. I think therein lies the problem.

Mr. MICA. Dr. Sanders?

Dr. SANDERS. This is a point I find very difficult to understand in relating to the previous comments. There are 35 million people in this country who have been disenfranchised from health care; they've been disenfranchised because there are economic barriers to their getting that health care. And the reason for those economic barriers relates to the incredible cost escalation that has developed within the existing traditional system.

Now, show me one physician that is not a businessman.

Show me a physician who is in practice for charity. You'll find a few of them at some of your teaching hospitals, but the majority of physicians in this country are in practice and are making a profit, and if they were not making a profit, we probably would not have 35 million people in this country disenfranchised.

So, whether we allude to a concern that a contract should be with, quotes, "a physician," versus a businessman, I think is a difficult one to stand on. I think the issue is that one has got to deliver appropriate care. There is constant allusion also to the fact that if there is a profit motive involved in an HMO prepaid system, that that will automatically lead to a decreased amount of care.

Well, it probably will lead to a decreased amount of care, but that does not equate with a decreased quality of care. The biggest problem in this country, from a medical care standpoint, is overutilization. Excessive care has led to poor medical care.

Underutilization, true underutilization, will also lead to poor medical care, but decreased medical care, relative to what we see in this country at the present time, does not equate with poor quality.

We have got to come to grips with what is appropriate care, and I don't think we've done that. We keep swinging from one end of the pendulum to the other, overutilization or underutilization, and it's someplace in the middle, and we need to define that.

Mr. **Mica**. Well, I'm not going to get in the middle of this argument because we're trying to get testimony, but it seems to me there is a point to be made that if money is being taken that could go to health care, and is used to build buildings and administrative facilities and so on, rather than just the amounts that go for doctors and for specialists, with some set aside for the service that's provided, there'd be a lot more money for medical care; isn't that——

Dr. **Sanders**. That's correct.

Mr. **Mica**. It sounds—it stands to reason.

Let's come back to the financial side of IMC, if I may.

You have no money outstanding, but I must say, frankly, you're only 10 percent the size, and you haven't experienced the growth that IMC has experienced in the last 2 or 3 years, and you may in the next 3 years be that big.

IMC, on the other hand, has been the subject of heavy criticism this morning that their bills aren't being paid. Can you tell me again, for the record, your understanding of IMC's financial status; that you have enough money, on a current basis, to pay all bills?

Mr. **Cohen**. IMC has enough money to meet its current liabilities as they become due—to meet all of its liabilities as they come due in the ordinary course of business. I think that somebody from HCFA had testified that wasn't a concern of Baltimore, which is the funding source. We—you know, we meet our bills as they become due.

Unidentified Speaker. When?

Unidentified Speaker. Sure you do.

Mr. **Mica**. All right. Let me do this. Normally there is another Congressman, from a different area, who is in charge of crowd control but I happen to be chairman of this meeting, so let me just tell you this: If we're going to proceed, I can't even begin to let comments start to come from the floor or it will get out of hand, so let's just stop right here. We'll continue to try to ask questions.

In Washington, the older, tougher, meaner chairmen clear the room and I don't want to do that but I do want to ask some questions about that, because probably the No. 1 complaint we're getting from hospitals is that their bills aren't being paid, and the complaint from individuals is that they're getting dunning notices from people saying they're not paying their bills.

I don't understand that, and the testimony all day today has pointed out that the only HMO in the country that we're having this problem with is right here.

Mr. COHEN. As I said earlier at the Boynton Beach meeting, we experienced a problem with our claims processing system starting in September or October. We started to address that problem in December or January with developing a new claims processing system. Approximately 30 percent of our bills, perhaps even a bit more, come in in the fashion that the gentleman from the other HMO discussed, they come in incomplete, they come in without the appropriate authorizations, they come in without the attendant information, which we must have, which any intermediary must have, which Blue Cross must have, in order to pay those.

Those bills then have to go back through the system. Now, that is the process that causes the kind of reaction that you hear, that I hear, that everybody feels very badly about. When those bills have to go back through the system, they take a lot longer, they don't come back; any kinds of problems happen with those 30 percent of the bills that come in wrong.

Now, almost intermediary in the county at some time or another, in developing a payment system, has experienced the same kind of situation. Probably—and I don't remember, but I think it was 6 or 7 or 8 years ago, the intermediary payer—and the gentleman from HCFA, perhaps, could correct this—was an outfit called "Group Health" here in Miami.

Group Health is an outstanding national organization. They had their contract canceled as a payer because of the problems in the payment process; they experienced the same kind of growth and they didn't solve it.

Blue Cross of Florida at one time or another, and probably if we were—if we put ourselves back in place 20 years ago, when the Medicare system was only 4 or 5 years old, we would probably go through the record and see the same kind of situation—where people were not getting reimbursed from the Medicare process, because it grew so rapidly and it was not anticipated.

The brochure that the gentleman from Av-Med, that's just passing out to his members, is a wonderful process. The HMO industry is a new industry. We are a provider of services and not an insurance company. Everybody is learning, and everybody has to learn that process, and everybody—a part of the process has to strengthen that process. You know, we are trying to, we are working with the system, we are trying to work with the regulators, we are trying to work with the providers, we hold continual meetings with the providers and try to get that process in place. We have not done the kind of job that we would be proud of, and if we had, we wouldn't be sitting here having this type of discussion.

But we are providing that health care in a fashion that is new to the entire industry, and that is a part of the problem.

Mr. MICA. Well, now, we're talking about then your delay in payments to hospitals and doctors as a result of uncompleted on paperwork. I have a statement here from a doctor that indicates—and I don't even want to use the figure, but it is in the millions, that he has tallied up from his colleagues, that is due from IMC, that he knows of no paperwork problems—it's just money overdue.

What percentage of paperwork problems is it; are there other problems where you're just not making the payments on time and they're due the money?

Mr. COHEN. No. We are processing—for instance, we process three times a month. We process bills on a 30-day cycle, just as the gentleman from Av-Med discussed; that a typical norm in the industry—Blue Cross processes 30 to 45 days—I mean 30 to 35 days.

Mr. MICA. So every——

Mr. COHEN. The process is the same; we process three times a month, we process claims.

Mr. MICA. Three times a month, everybody that's due money, except for paperwork problems, gets all the payments?

Mr. COHEN. That's correct.

Mr. MICA. I have to tell you this: It doesn't match with what we're getting. Now, we'll have to take a look at it, but it doesn't fit. We can go back and contact everybody who's told us that they have payment due, and find out if they've been notified there's a paperwork problem or they're just not getting it.

But from my recollection and my review of the files it doesn't—from some of the information we've been given, that does not mesh with what we've been told.

Do you have an escrow account to pay specialists or to pay others outside your employ, contract doctors and so on?

Mr. COHEN. No; we do not have an escrow account.

Mr. MICA. What account is that paid out of?

Mr. COHEN. We have a general—we have a general operating account and a claims account.

Mr. MICA. Everything is paid out of the general operating account?

Mr. COHEN. And the claims are paid out of the claims account. I don't understand the word "escrow account payment." I don't think health maintenance organizations or I don't think any payers operate with escrow accounts.

Mr. MICA. Well, now, Mr. Portnoy, explain to me, you told me you escrowed a certain percentage of the money——

Mr. PORTNOY. The way that we work it, the way that we work with our primary care physicians in this area is that under the Part-B money, which is approximately $77, the primary care physician gets $43. The balance is put in an escrow specialist account, so that the money is there when the bills become due. The primary care physician does not get that.

This was organized at the suggestion of the primary care physicians, and the specialists, so that everybody would be sure that there was money there to be paid when the services arise.

Mr. MICA. And you're saying——

Mr. COHEN. You should understand that Mr. Portnoy's company is not an HMO. Mr. Portnoy's company is an intermediary between the HMO and the provider of services. As he said, he is a management company that is taking the capitation payments from the HMO and turning around, and has capitation agreements or payment agreement, with providers of services.

Now that—we have agreements like that. We have management companies, as you've heard the term affiliated providers, we have some affiliated providers that operate in the same fashion, where they act as an intermediary and, in turn, contract with various providers and hold funds in escrow. We are discussing one such agreement with a group of 26 physicians in Broward County, currently, to do that.

But that company is not an HMO. The HMO is a different organization.

Mr. MICA. But your contention is that the way you operate wouldn't benefit by having a separate account, escrowed moneys, to pay outside physicians?

You have enough money——

Mr. COHEN. Yes; yes.

Mr. MICA [continuing]. Three times a month to pay everybody with no problem?

Mr. COHEN. Yes. We pay three times—we process claims three times a month, and we process all claims that are in the house 30 days or more in those three-times-a-month cycles. That's the way we process claims.

Mr. MICA. OK. Let's just leave that for a minute and go back to 6 or 8 months ago when we had this great increase in complaints with regard to your organization. What happened 6 or 8 months ago that, No. 1, caused everyone to call us all at once saying they're not getting your payments, and No. 2, caused these complaints to increase?

As I said very freely, after the last hearing, when we were looking at this before, we went through a year where everything that we heard about HMO's was wonderful; payments seemed to be on schedule and everything seemed to be going well. Now, we're at a point where the testimony indicates that seven of the eight, or eight of the nine are doing wonderfully; one, your organization, is way behind, or appears to be way behind on some payments, and it all started, you say—you said earlier this morning that, "Yes, we had some problems that arose 8 or 9 months ago." We checked our records, and our office had an explosion in complaints that started 8 or 9 months ago. What happened then?

Mr. COHEN. Two things, and I was—I guess I was not part of the organization then, but that's not an escape.

Two things: The company had an explosive growth approximately a year ago that precipitated tremendous membership accretion both in—in all of the areas.

Second, as a result of the growth, the infrastructure, the organization infrastructure that handled that growth was not kept at the same pace, and the claims started to back up; the process, the physical processing of the claims started to back up. So, instead of a claim being processed in 3 or 4 or 5 days, the claim was being processed in 14 days.

Somewhere in the month of October or November—I think October—an entire piece of the data base got lost out of the processing system, and that was the time that this—you know, complaints and everything started to escalate. We simply did not have the claims in the data base. That's when I said to you earlier, we started to rebuild the claims systems. The claims system just expanded past the ability to handle it.

Mr. MICA. Well, now this is the first time we've heard anything about that. Let me just ask my staff: Have we any information on that?

Ms. BELLOWS. Never heard that before.

Mr. MICA. What you're saying is, that you had a major loss of data information on your computer in October and——

Mr. COHEN. Only in claims.

Mr. MICA. In claims—and that's the problem that we're—I have—I have to tell you, we have not ever heard that before. That is the first time. Have you notified your providers, or anyone, that you had this problem?

Mr. COHEN. We have talked to some providers. I have talked to some providers about this, on a one-to-one basis, and——

Mr. MICA. How many records did you lose?

Mr. COHEN. Approximately, and I don't know—I don't know.

Mr. MICA. Can you give me a close guess?

Mr. COHEN. Five thousand or so. I mean there have been a lot of organizations that were heavily based upon data in a computer system which experienced similar problems. We are not unique to that.

Mr. MICA. All records, everything for those 5,000?

Mr. COHEN. No; just the claims piece.

Mr. MICA. Is there any way, for instance, you could match those 5,000 against the complaints that I have in my office? That may settle a whole list of them.

Mr. COHEN. That's entirely possible; that's a good thought.

Mr. MICA. We have never—I'm astounded, frankly. That wasn't even mentioned this morning.

Mr. COHEN. Well, I did say to you that we had a problem, a major problem, in October with our claims processing system.

Mr. MICA. Yes, you did; yes, you did, but you didn't tell us that.

You know, it may be that we can solve a great deal of the problems right here.

Let me just ask you this: I run a small congressional office, 24 people, and we do a backup of our computer every day; do you back up your systems every day?

Mr. COHEN. We back up our system on a scheduled basis, and it's not every day. We have three computer systems, but not everything is backed up every day. That's not unusual. Batches are backed up.

Mr. MICA. Do you have the names of the 5,000 you lost information on; can you separate them out?

Mr. COHEN. We have reconstructed perhaps, as a result of getting dups—you know, to get people exactly what you're saying—getting the duplicators in, we have probably reconstructed perhaps half of them.

Mr. MICA. Half of that.

Mr. COHEN. Now, understand, we process approximately 65,000 claims a month. So you have to put the 5,000 in perspective.

Mr. MICA. Well, I do, but I must say, I'm just astounded that I hadn't heard anything about this until this hearing today. Probably, with all the complaints we've had, if somebody just called our office and said, "We've had a major computer problem, give us a list of the names and we'll try to patch them up," we could have avoided a great deal of this problem.

I am astounded really that we're here in this session.

That solves the billing problem, or at least for 5,000 people. What about the quality problem, what about the referral?

Dr. Sanders, do you want to respond to that a little bit? We've had a large number of people who've claimed they're dissatisfied with being referred. We've had—you've heard the representative testimony this morning. Let me tell you: We've been as fair as possible. We've had people who wanted to come in here and scream and yell and beat on the walls, and I know you've heard some—and we tried to be fair, but those—that case where the woman's father died, and so on, this morning, those are very representative of what we've been hearing, that people aren't getting referred to specialists, and aren't getting the kind of care they want.

What kind of response do we have to that?

Dr. Sanders. Well, the response is: I don't mean to make it a simple response; it's really not a simple problem, but the issue is one that was alluded to already in terms of the comments made by the representative from Av-Med, and that is we need to do some education relative to the difference between patient expectation and actual medical care that is required.

There has been a great explosion in this country in terms of individuals becoming a lot more responsible for their own health care—that is a very positive side, but it has a potentially negative side, and that is that there is a great expectation that for every ailment that exists, one needs to have a specialist.

Now, there is nothing—I am not in any way trying to condone or justify inappropriate underutilization of health care services, and I would be happy to review every situation and have our quality assurance team review that, or any external auditing group review any of the allegations that relate to the fact that necessary subspecialty care was not provided to a patient, but I think we have got to come to grips with the fact that if the primary care provider, if that Board-certified general practitioner or internist states that he can take care of that particular problem without the necessity for a subspecialty referral, then you're always going to have difficulty in explaining to the patient that, "I do not feel you need to go to the gastroenterologist or go to the cardiologist," but I do feel there are probably situations—and I would be happy to look into those—in which subspecialty referrals were probably not provided.

So the simple answer to your question is: I would like to review each of those; we can do it internally, or I would be happy to participate with any external audit process to review those cases, but I will say that we have got to have a perspective in terms of an individual's expectation and what the reality of the medical care process is.

Mr. Mica. Unless my colleague has a question, I have a hundred new questions now, but we're going to have to move on to the next panel.

I'd like to advise the witnesses that we're going to leave the record open, and if you'd like to submit any additional testimony—I'd like a confirmation on the number of names that were lost in this computer breakdown, specific number of names, and, in fact, if you could provide those names to my office, at least it would be very helpful to cross-check on all the cases that we have pending.

Mr. COHEN. Well, it would be hard. As I say, we've lost them and the rebuilding of that is the claims coming back in through a process of people saying, "We haven't been paid," and matching it against the original file.

Mr. MICA. Then I misunderstood you. You've lost not only the file, but the actual names as well.

Mr. COHEN. That's correct.

Mr. MICA. You've lost everything.

Mr. COHEN. No; that is not correct. I said we—in the computer file, approximately 5,000 claims, that's all; not names of people, our entire membership file, our entire medical history file.

Mr. MICA. But wouldn't the claims be filed under the name of the patient?

Mr. COHEN. No. Our claims are filed by to whom they're paid to. See, we do not pay claims—we are not an insurance company making payments to individuals, we are a provider making payments to other providers.

Mr. MICA. The point that I'm making is: If you have 140,000 HMO members, you have 140,000 names; you mean to tell me there isn't a file out there that says that when you pay a dollar for one of those, that it doesn't go in that record?

Mr. COHEN. When it's paid, that's correct.

Mr. MICA. When it's paid.

Mr. COHEN. But until—when it goes through the system of verification against the membership, verification against the provider, verification of the contract amounts; until it gets to that point, it's still in a process; that's correct.

Mr. MICA. And the system that you have only keeps the claims separately, it does not enter a claim in or mail in, mail out, or anything, so there'd be a record of the people—even if they weren't paid yet?

Mr. COHEN. We—at that point in time, the system did not have that. We now have that ability; we now have that capability, and you know, a company learns by some mistakes.

Mr. MICA. Well, I, unfortunately, will have to submit written questions, unless my colleague has any questions. Time is pressing here.

I would like to visit with you—at least on this particular subject—for a minute as soon as the hearing is over. I am really astounded that we're here on this basis, and maybe we could have solved a great deal of this if we had this knowledge. Now, there are a whole list of other problems, but this is one of the biggest ones.

Just quickly, can you tell me, would that have any bearing on the outstanding claims that we're talking about this year for doctors, or would that all be last year; doctors and hospitals?

Mr. COHEN. I'm confused as to years.

Mr. MICA. All right. A hospital or a doctor has filed a claim in January or February and waiting for payment and they haven't gotten it yet.

Mr. COHEN. No; that would have no bearing.

Mr. **Mica**. No bearing. So all of the money that people claim to be owed, if they're owed this year, has nothing to do with that mistake from last year?

Mr. **Cohen**. With that issue; that's correct.

Mr. **Mica**.. Thank you.

Mr. **Cohen**. Claims that are filed in February, would just be in the process of being paid in the last week or two or the next week depending upon the time cycle.

Mr. **Mica**. Our next panel—thank you for being with us—consumers; Myer Dworkin and Irving and Irene Bleiweiss.

Mr. Dworkin, would you like to go first?

PANEL THREE—CONSUMERS: CONSISTING OF MYER DWORKIN, BOCA RATON, FL; AND MR. AND MRS. IRVING BLEIWEISS

STATEMENT OF MYER DWORKIN

Mr. **Dworkin**. I would like to preface my written statement with a remark.

I come from Worcester, MA. We have one of the most prestigious HMO's there, the Fallon Clinic. When I came here, I expected the HMO's here to be something like the Fallon Clinic that we had in Worcester, MA—nothing like it happened. Nothing could be further from the truth.

This is my written statement:

My name is Myer A. Dworkin, and my wife's name is Jean Dworkin. We reside at 9660 Southwest 14th Street in Boca Raton. My testimony today concerns the quality of care given my wife by IMC during an episode which occurred late last year. The statement which follows is really part of my diary from that period, which was written at the request of my lawyer.

Today is Thursday, October 24, 1985.

Mr. **Mica**. Mr. Dworkin, let me interrupt just a moment.

Mr. **Dworkin**. Yes.

Mr. **Mica**. You have certain privileges before this committee, but I would advise you that—particularly if you are dealing with a lawyer—that you not mention any names of doctors or individuals as you proceed.

Mr. **Dworkin**. I have not. I have only initials.

Yesterday, Wednesday, October 23, I saw my wife, Jean, at Florida Medical Center in the psychiatric ward. Together we saw Dr. W., a psychiatrist. He holds some hope for my wife who attempted suicide last Friday, October 18. Dr. W. told us, without being told by Jean, exactly where her symptoms were prior to her attempt, that it followed a usual pattern that should have been recognized; that is, loss of memory, withdrawal and insomnia.

It started last June. Jean asked IMC for a checkup, her complaint being extreme fatigue. Her checkup proved negative and physically everything was OK, they say, yet, Jean continued to complain. In August and September, she complained of all these symptoms plus extreme depression. Again, she saw her IMC doctor, Dr. S., who prescribed antidepression pills. It did not seem to do any good and she complained again and again threatening suicide. When Dr. S. heard that, he immediately recommended her seeing a psychiatrist and recommended one that he knew of. Obviously, the medical director thought otherwise and sent her to a psychologist, Dr. D. Jean saw Dr. D. on Wednesday, October 16. After more than an hour, Dr. D. took me aside and told me my wife required immediate attention; a neurologist, brain scan, et cetera. That her threat of suicide was very, very real. Dr. D. further stated that she was going to call a Rose Marie at IMC that following morning and tell her that Jean was top priority and to forget the paperwork, that it would follow.

I called the following morning and Rose Marie would not come to the phone. As a matter of fact, I called repeatedly all day Thursday and got the same answer—that Rose Marie was in conference. Dr. D. has since called me several times and tells me that not only did she call, but wrote a report saying Jean must have immediate attention—underlined and in capital letters. She tells me the original report is in her file, but that she cannot give it to me.

I asked Dr. D., "Who is Rose Marie," and the answer I got is, "She is the assistant medical director who assesses what is not an emergency and what is—with no medical background." Dr. Marino, the medical director, is not available on Thursdays. In several instances, during our conversations, IMC personnel seemed to be disappearing to get direction from a George Picaza, who I believe is the son of the owner of the HMO at 19807 Hampden Drive, who I also believe has no medical training. Who then makes decisions on a medical basis? I finally got Dr. S., her original doctor, who said that he was completely unaware of all this, and that this Rose Marie had not even discussed it with him. All day Thursday, I called pleading for help; that my wife was walking around holding her head. I continued asking for help, "Please, tell me where to take her?" The response was that if I would take her, I would pay for it myself. I told Rose Marie I understood all that, and IMC's answer was that there was no emergency, and that they would look into it the following week. Meanwhile, in desperation, I called Congressman Mica's office to try to get assistance from IMC. This was Rose Marie's assessment, because a psychologist, Dr. D., said that Rose Marie had lied. Dr. D. said there had to be an immediate concern, nothing like the following week.

On Friday, October 18, early in the morning, my wife swallowed pills with Clorox even though she cannot stand the smell of it. We became aware of this at 9:30. IMC was called by my daughter, who requested an ambulance and told them there was a possibility of an overdose. Again, Congressmen Mica's office was made aware of this. At 10 o'clock, the ambulance finally arrived—after two phone calls. Mother was brought to the emergency ward—this is my daughter—at the northwest regional where her stomach was pumped. Neurologists and all kinds of people were there. From there on in, she received excellent care.

After a few days she was transferred to Florida Medical Center for about 5 weeks. She is still under the care of Dr. W., who tells me that to date, IMC has not paid his bill, nor any of his consultants.

One last comment from my notes of October 23: Today the most peculiar response to my request to IMC for renewal of my mild sleeping that I take when my leg aches. I have very little or no circulation in one leg; although I first take aspirin, I do not like to take sleeping pills because they are habit forming. If the aspirin does not work, I then take a pill called Restorill.

The response of IMC, through a nurse called Doe, was that Dr. Marino told me to get it through Dr. W., my wife's psychiatrist. I saw Dr. W. at the hospital and he did not believe me, and he told me I was not his patient, Jean was. Actually, I think, he thought I was crazy. Meanwhile, IMC changed their minds and gave me an appointment with Dr. S., who then gave me a prescription. Dr. S. informed me his hands were tied. That all his referrals were constantly being refused. These are my observations. I do not think Dr. S. will stay there very long as he finds the conditions intolerable.

Thank you.

Mr. MICA. Thank you, Mr. Dworkin.

Let me now call on Mr. and Mrs. Bleiweiss.

STATEMENTS OF MR. AND MRS. BLEIWEISS

Mr. BLEIWEISS. I would first like to thank Congressman Mica and Congressman Boucher for the opportunity to testify today before this panel regarding my experience with health maintenance organizations, specifically IMC HMO.

I would like to point out that the problem that exists has happened to my wife, Irene, however, she has just been discharged from the hospital and is under medication and not really up to speaking before the panel. I was present at all my wife's office appointments and can accurately tell you today what transpired.

I originally joined an HMO group plan for several reasons—the biggest reason being cost. Due to escalating health care costs, I was forced to examine other plans, other than the one I had, in search of a less costly plan. I found IMC's HMO to be affordable, so I joined it along with the rest of my group. I was assured by the HMO people that I would receive the same quality care that I had enjoyed with my own private physician.

The first month that my wife had an appointment, we explained to the medical physician, the primary physician, that my wife had a pacemaker, and that she was required once a month to have a pacemaker check—for her physical as well as her mental state of being. Two years before, my wife had had a pacemaker and the anode wire had broken off inside her body. Therefore, her cardiologist, at the time, suggested that she have monthly checks, which she did, under her private physician's care. The doctor said this would not be a problem with the HMO, and the medical assistant in charge of the office said my wife could come in the first Friday of each month, before she went to lunch, and have an EKG done.

When we arrived the second month for my wife's appointment to have the pacemaker check, the medical assistant told us that she was alone that day and asked us to come back the next week to have one done then. So we came back the next week and the medical assistant again told us that she could not because one of the women from the office was at a seminar and she did not have the time.

I want you to understand that I have to take off from my own work to take my wife to the physician. When we arrived the third week, the medical assistant again told us that she could not do the test, and she replied that my wife did not even need the test since she had had an EKG done less than 2 months ago, and under Medicare requirements, she did not have to have one but once every 6 months. We could not believe that medical assistant could change a physician's orders and make a decision regarding my wife's condition when she did not even attend medical school. My wife was very upset, and I called the HMO's 800 number, but received no satisfaction; in fact, they did not even bother to return my call.

At my wife's next appointment, she complained to the doctor of chest pains, nausea, and shortness of breath. The doctor, in turn, wrote an order to have an EKG done and gave the order to the medical assistant—explaining that my wife was experiencing chest pain. We could hear the entire conversation from the office next door because the place is nothing but tissue-paper partitions. The medical assistant told the doctor that my wife had had an EKG recently and that she did not need one, and she pulled out my wife's month-and-a-half old report and physically threw it all on the doctor's desk. The doctor further explained to the medical assistant that her condition warranted this test to be done, where, in turn, he was told, "It was none of his business," and he was to stay out of it. As I said, we could hear it all through the partition. The doctor threw up his hands and said he was powerless to do anything. My wife then asked him how an assistant can dictate to a doctor what should or should not be ordered. He said, "She runs the office, she can make these decisions."

I was incensed. I went downstairs, I called the 800 number, that is posted on the wall, again. I told the woman that I had called previously and had had absolutely no response, as I was promised, within the 2-day period of time. The woman told me she would write it out, give it to the administrator and see that I was called because it was now very important. They never bothered to call me again.

My wife still was having pain, nausea, and shortness of breath; I took here home. That night, she went to a Mah-Jongg game, came back and said to me she did not feel well, in fact, the pain was getting worse. I called the 800 number that was given to me, and was told to take her to the nearest hospital emergency room, which I did. She was admitted as a cardiac patient to the telemetry floor, and was there for 6 days being monitored.

After my wife was discharged, I took her home, and the ironic part about it was—I then received notice from the Cordis manufacturer of the pacemaker in her chest, that the approximate 8-year period of time, that the pacemaker would be good for, had been shortened to 5 years, under severe testing, and that within the last period of the 5 years, she should be monitored within a monthly period of time because it may only have a 30-day period of time left on the batteries. My wife had had this one in her chest for over 3 years—so she had a pretty darn good reason for being worried.

My biggest complaint above and beyond this, other than the fact that this woman is completely unfeeling, because we gave her a copy of the certified letter we had received from her cardiologist with the material from Cordis, was, "Well, it has a 69-percent chance of lasting the full 5 years, I do not see why you have to worry." It is marvelous when you are playing dice with someone else's health.

My greatest complaints are: My wife cannot call up her doctor to complain to him personally; she has to go down whenever she has to see him. He is not available to her on the telephone.

When she was discharged from the hospital, the prescriptions given by the doctors, who were not HMO doctors at this hospital, because it was not an HMO hospital, had to be taken back to the HMO to be rewritten by her primary doctor--as they were not acceptable by the HMO.

My wife has been to see three different referred doctors. They have all been very good, but they have all been at least 20 or 30 miles away; the gynecologist is in Miami, the ophthalmologist is in Hallandale, the cardiologist is in Hollywood, and I am afraid to ask for anything else because it might be up in Boca.

Thank you, sir.

Mr. MICA. Thank you.

[The following supplemental material was submitted by Mr. Bleiweiss:]

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January 9, 1986

IMPORTANT PACER INFORMATION

Revised Service Life Predictions for Gamma Series Pacers with Polypropylene Protected Batteries

Cordis is reducing the service life predictions for Gamma Series pacers with polypropylene protected batteries although they have generally demonstrated excellent clinical reliability. They will operate normally except for the earlier than predicted appearance of the rate decrease which indicates the time for replacement. Safe operation at the lower rate will continue for up to several months, but in some instances for only one montn.

Upon approaching the revised service life in Table 1, Cordis recommends monthly monitoring of patients on the attached list. A suggested date to start monthly monitoring which is three months prior to the revised service life is provided in the list for each patient.

Table 1

REVISED SERVICE LIFE PREDICTIONS

Model	Years
308A, 333B7, 333D7, 334A, 335B7, 336A, 336B, 337A	5
342A7	4
402A, 402B (73 early units only)*	4.5

* Most model 402 pacers have polyimide protected batteries. Prediction applies to outputs of 0.6 ms/6 mA or lower which do not activate the voltage doubler.

Basis for Revising the Service Life Predictions

Gamma batteries with polypropylene protected feedthroughs were introduced in 1980. In the first three lots, the barriers were not totally effective, as described in a March, 1985, Notification. In subsequent lots, pacers with these cells have exhibited excellent reliability (97.9% at 59 months).

The original published service life predictions for pacers with Gamma batteries were calculated from the specified Gamma battery capacity. However, long-term accelerated current drain tests on sample cells now indicate that most of these cells will deplete earlier. Table 1 provides revised service life predictions based on the accelerated current drain tests results and the achieved reliability of Gamma pacers.

Early units of model 233F and 415A pacers with hermetic Theta cells may not achieve their predicted service life because these cells have polypropylene protected feedthroughs similar to those in the Gamma cells. If the reduction in service life were proportional to that in the Gamma Series pacers, the revised service life prediction for these units would be seven years. However, there is no basis at this time for a reduction in service life because no early depletions of Theta cells have been reported after up to 42 months of implant or in the accelerated current drain test. In addition, the Theta cells have a much higher capacity and approximately 27% thicker polypropylene than the Gamma cells. Cordis will continue to monitor model 233F and 415A pacers with polypropylene protected Theta cells and report on their performance periodically.

Gamma and Theta battery feedthroughs are now coated with polyimide, a chemically resistant polymer, which is permanently bonded to the feedthrough to create a barrier to prevent electrolyte attack. Cordis expects pacers with polyimide protected Gamma and Theta batteries to deliver the original predicted service lives, and this notice does not apply to these units.

The FDA has been informed about this communication. If you have any questions regarding this information, please call the Cordis Customer Service Department at 1-800-327-8085 (1-800-432-6565 in Florida) or contact your local Cordis representative.

IMPORTANT:

Please acknowledge receipt of this information and the attached list by signing and returning the card to your Cordis representative. The returned card will help assure that all affected physicians receive this information. Also, please notify Cordis immediately of any patients you are unable to locate for monitoring to enable Cordis to attempt to locate them.

Mr. MICA. We will not question the panel at this time. We may ask for some validation, some information on your testimony at a later time.

Let me divulge this, just so there be no question. Mr. and Mrs. Bleiweiss requested the opportunity to testify here today, and we granted it—even though their son is a member of my staff. Thank you.

We will call up the next panel.

Mr. William Stafford, director of the Broward County Medical Association; Mr. Jim Rogers, assistant administrator, Northwest Regional Hospital; and Victoria Alegre.

Let me make a point here. A gentleman just mentioned here that these comments today—they would like to have an opportunity to speak from the floor, and I wish we could provide that today, and also that these comments are all anti-HMO.

Let me tell you: I have prided myself in my career in Congress to try to have balanced hearings in any hearings that I oversee. Two years ago, when we had HMO hearings, we had HMO proponents and opponents in the audience, and at the end, we let people line up on each side and gave them each 1 minute pro and con.

Frankly, it gave everybody a chance to get a little bit off their chests, but it did not add any new information. We have tried not to get into that situation. It also let some people yell and scream without factual information; some do have it, some do not, and I know that well over half the people who are served by HMO's—three-quarters, in many cases, are very satisfied, and I have tried to make that point in my hearings. But, in fact, in trying to be fair, we decided not to get into a situation where we would have a lineup on both sides shouting information that we have no control over, and that is why we are doing it this way.

I invite you—in fact, I plead with you—if you have any information praising or condemning HMO's, please give it to us in writing. We just found that, when we did this 2 years ago, to have people screaming from both sides did not serve the process appropriately.

Ms. Alegre, could you identify yourself; my sheet does not indicate your affiliation.

Ms. ALEGRE. Yes. I am the office manager for a local private physician who is not contracted by an HMO, and we would like to express the problem that we have in dealing with HMO patients through emergency situations which we have no control over.

Mr. MICA. Well, since you have the microphone, why don't you proceed.

We were supposed to clear this chamber at 4:30, so we will try to proceed as quickly as we can, and have you make your statement, and we may have a little time for questions, or we will submit them in writing, but please proceed.

PANEL FOUR—MEDICAL PROFESSION: CONSISTING OF VICTORIA ALEGRE, OFFICE MANAGER FOR PRIVATE PHYSICIAN; JAMES ROGERS, M.H.A., ASSISTANT ADMINISTRATOR, NORTHWEST REGIONAL HOSPITAL, MARGATE, FL, ACCOMPANIED BY DR. NEIL SCHULTZ; AND WILLIAM G. STAFFORD, EXECUTIVE VICE PRESIDENT, BROWARD COUNTY MEDICAL ASSOCIATION, FORT LAUDERDALE, FL

STATEMENT OF VICTORIA ALEGRE

Ms. ALEGRE. I can appreciate the statements that are being made by HMO's, as well as those condemning HMO's. The questions we have, as a private physician in the area who is not contracted by an HMO is the problem we have getting paid, which I think you have already heard here today.

HMO's have expressed an interest to educate the participant on how they must involve themselves in their own care and see that they go to the proper facilities.

Our point is this: As a physician in the area, he is on ER staff, he is a surgeon. Through being on ER staff, you are not—you do not have a choice of taking a patient or not taking a patient. When it is presented in an emergency situation, you must treat the patient.

Mr. MICA. "ER," you mean emergency room staff.

Ms. ALEGRE. Emergency room services.

We are called in as an emergency room consultation; it presents itself as an emergency situation that must have surgery immediately. That surgery is done, the service is provided to that patient, not to the HMO. We, in turn, must bill the patient; the HMO is saying, "Don't bill the patient."

Well, as we do for all of our patients, we bill the insurance company that they indicate is the responsible party. We bill the HMO and the average claim is 6 to 7 months to be paid; we have some outstanding as long as 14 months, and they vary from IMC to the local area HMO's.

I have gone to IMC. We are on file with the Insurance Commission with our complaints, we have done everything possible and called every office possible to get these claims taken care of, but our point is this:

A health maintenance organization is a preventive maintenance organization and it is very difficult to give preventive maintenance to the senior citizen who more than likely already has the problem that you are trying to prevent, and because of that, when Mr. "X" collapses from his heart attack or his failed pacemaker—that happens in public or in the deli, and they are taken to the nearest hospital facility, as you have heard here today, and that is when they encounter that private physician, that private physician has to provide that service, and when he does that, he does not get paid. And that is the complaint here.

And second, we have no governing body that we can go to to see that something is done. There seems to be no control factor on the HMO or the IMC, and as I understand it, hospitals are allowed to bill either the HMO or Medicare; there is a recourse there for the hospital; there is not that recourse for the private physician who is not an HMO contract physician.

So, we are not putting down the HMO's, if they work with the people, that is excellent, but out point is this: At least 75 percent of the people in the HMO or IMC are elderly participants, so you have people here who are very likely going to encounter this situation of emergency treatment being outside their HMO facility.

Mr. MICA. Thank you.

Mr. Jim Rogers, assistant administrator of Northwest Regional Hospital—right up the street.

Mr. ROGERS. Good afternoon.

STATEMENT OF JAMES ROGERS

Mr. ROGERS. I wish to thank you for allowing me the opportunity to address you on this most crucial topic of HMO's and their impact on the quality of care in our area.

I would like to preface my remarks in saying that we, too, deal with many HMO's in this area, and the one previously mentioned seems to be the one giving us a lot of problems as well.

While HMO's from a conceptual perspective seem promising toward the goal of reducing health care expenditures, it is my feeling that expenditures are being reduced at the detriment of the people and the quality of health services they receive. In short, some patients are suffering due to the economic incentives inherent in the HMO's to provide patients with the least amount of services possible. Some HMO's are better than others in this regard, but quality cannot always be assured.

The negative impact of HMO's on the quality of care is derived from the following problems that we, as a hospital, face almost on a daily basis. These are:

The secondary treatment of patients is delayed in our emergency department due to an ineffective HMO bureaucracy that is slow in authorizing admissions. Also, it gives us problems in locating the exact HMO contract physician who may be on duty that night or that holiday or that weekend, if necessary. We encounter a long delay in trying to arrange a transfer of a stabilized patient to a facility that does have an HMO contract.

Mr. MICA. Can I interrupt you right here. This came up this morning. A patient presents himself at your door asking for admission, says, "I am an HMO member." What do you do—do you have to call the HMO and confirm that they are admitted?

Mr. ROGERS. Our policy is, of course, we examine the patient initially. Once we decide that admission may be necessary, we must call the HMO to get an "authorization number." If we do not have that number, then that patient in our terms is indigent and we usually do not receive billing from the HMO, and we can only, in turn, bill the patient.

To correct what you said, ma'am, we cannot bill either the HMO or Medicare or both, it is one or the other, and if it is an HMO patient, we face the same problems that the physicians do in getting HMO payment.

Mr. MICA. Emergency cases?

Mr. ROGERS. With respect to the charges incurred in the emergency room?

Mr. MICA. Do you call for authorization?

Mr. ROGERS. No, we just go ahead and treat the patient, sir. We do not waste time in calling for authorization. We have had numerous problems getting put on hold for hours, hearing that somebody would call back and never getting called back; so we do not waste that time. We go ahead and treat the patient.

Mr. MICA. What is your understanding as to what you are supposed to do through as far as the HMO even on an emergency patient?

Mr. ROGERS. The HMO usually, if the emergency is justified, will make payment for that emergency room visit.

Mr. MICA. But you do not have to get a clearance in advance.

Mr. ROGERS. No, we do not.

Mr. MICA. Please proceed.

Mr. ROGERS. Another concern we have about HMO's is that the acuity levels of illnesses are increased perhaps due to patients delayed the care that they should promptly receive. And I think this has been sufficiently addressed earlier.

We do see patients that arrive to us on, "Death's doorstep," because they have been denied initial essential care. Once we get them up into the intensive care unit, it takes a greater amount of services to get them back to where they were than if the HMO just would have admitted them in the first place.

The third point is——

Mr. MICA. Can you document cases like that?

Mr. ROGERS. Yes, I believe I can, sir.

The patient's well-being is also at risk due to the constant pressure of the HMO care coordinators on members of our medical staff to encourage them to discharge the patient as soon as possible. Our physicians do not give into this pressure and discharge them when they feel it is medically appropriate.

The final aspect of the HMO model which impacts the quality of care is that the patients and the family are quick to blame the hospital and its medical staff members for problems which are not under our control. Not only is the patient emotionally traumatized by these HMO-related episodes, but they oftentimes lose confidence in the integrity of the health care system which they are now dependent upon to get them well.

It is customary to cite your reasons why the HMO concept is not contributing to or maintaining quality of health care. These reasons, in my opinion, are as follows:

Our medical staff physicians who step in to help an HMO are oftentimes paid a highly discounted fee or most of the time not paid at all. We hear a lot of complaints from our medical staff saying that they make numerous attempts to bill the HMO, they get things like, "Well, we lost that bill," or "We never got that bill, please send another," and they have repeated excessive delays that are concurrent with what this young lady just said.

The physicians on our staff do not resist or object to caring for indigent patients—that is part of the responsibility that comes with being on our medical staff. What they do resent is taking care of a patient on a Good Samaritan basis and have someone else make money on their Good Samaritan act.

And this is the problem we as a hospital face as the physicians are reluctant to come in and treat these patients if they find that they are an HMO patient, because they know that 9 times out of 10 they will not get paid.

Oftentimes, the HMO's use specialists who are not members of our medical staff. This causes many problems for the HMO patient in our ER who needs care. As you can derive from my previous comments, if the physician is not on the staff, we must go to the physicians who are not HMO physicians and ask them to contribute their time with the potential of not being paid. This, again, creates problems from the hospital's perspective.

Finally, we feel that the current Medicare demonstration project has been an administrative nightmare which has resulted in many patients in enrolling, disenrolling, and many times we have patients left with no verifiable coverage whatsoever.

In view of the aforementioned problems and issues, it is recommended that HMO's be heavily audited and regulated in the same fashion as hospitals are currently.

Also, it would be beneficial for HMO's to be required, by Medicare, to be accredited by the Joint Commission on Accredition of Hospitals or a similar body.

Finally, we suggest that HMO's are held liable for their actions, or inactions, which may result in malpractice and subsequent litigation against hospitals and physicians.

Again, I thank you for the opportunity to address this committee.

Mr. Mica. Thank you.

And our last witness, Mr. William Stafford, director of the Broward County Medical Association.

STATEMENT OF WILLIAM STAFFORD

Mr. Stafford. Mr. Chairman, Mr. Boucher, I will not expound on any of the previous testimony up to and including the last couple of years that we have been sitting at these hearings. I would like to offer some suggestions to you.

The horror stories are there, and if I may just tell you one that happened to me last Thursday on a phone call from a lady who was calling about her 83-year-old mother, who found that she was asked to go down for her physical examination by her HMO, which confused her because she did not realize she was a member.

Now, this is last Friday. The daughter was even more confused because her 83-year-old mother was blind and illiterate. I wonder about some of the recruitment measures that are going on—even to this day; we thought we had remedied most of those.

About a month ago, we had a similar hearing, Representative Clay Shaw had an interest in HMO's. Mr. Holland had some testimony, and you recall, 2 years ago, we were looking for some audit information for GAO. Mr. Holland's comment at that time was "that an audit was not indicated nor justifiable at this time."

I took violent exception at that time and I still do. I do not know whether you have ever gotten that information that you requested 2 years ago.

Mr. Mica. Not as a direct audit, but GAO is making some reports due any day now. They have been looking into the entire HMO situation and one in particular.

Mr. STAFFORD. Florida law, Mr. Chairman, says that there will be an internal audit. To me, an internal audit is like talking to yourself. We would suggest perhaps there ought to be an external audit accompanying that internal audit.

We would also say that that audit—I think probably Dr. Sanders would agree with me, as he mentioned the fact, that perhaps an external audit, both of fiscal matter and of the care provided is evident. You do it to your regular Medicare patients through PRO, you do it through hospitals with PRO mechanism, you do it with peer medical utilization review for your fiscal intermediary. That should be extended, sir, that is a firm recommendation.

We would also say that there—because of the complaint form, and I am sure every HMO has its own internal complaint organization that are responding to these. We would say, perhaps, that it might be expanded to an organization of an ombudsman to take care of a certain region or a certain State area, or to set up with a fiscal intermediary who might be receiving those complaints that you get, as well as I get.

That is a firm recommendation. That could be funded quite easily by a capitation thing.

Physicians are not against HMO's. In this area, perhaps 80 percent of our specialists and 30 percent of our general have contracts with organizations to provide services to their clients at fees lower than the doctors charge their own private patients.

The doctors in the State now are forming their own HMO's as a matter of competition against those existing and perhaps a portion of that is because of some anticipated legislation this year which would provide Medicare eligible with a capitation certification that he takes any organization that he deems fit to provide his medical care.

That is not law yet, but it is proposed. And I would think those physicians under those cases would form their own HMO's, under what guise or however form they would put it out.

We are pleased, from the testimony today, to learn that the return to Medicare has been expedited for people who are dissatisfied with the services; that was one of our main complaints before. But the other thing that I think is necessary—we are hearing, and I mentioned it myself, that perhaps we are proliferating HMO's, perhaps we are getting them to the point where they are coming in too frequently.

Perhaps if that competition is overbearing and overriding—and as we mentioned before, until we have such evidence that HMO's in their several forms are, indeed, cost effective, that perhaps there should be cessation of licensing and a cessation of funding to support these organizations until we do find that they are, indeed, cost effective.

Thank you, sir.

Mr. MICA. Thank you.

[The prepared statement of Mr. Stafford follows:]

PREPARED STATEMENT OF WILLIAM G. STAFFORD, EXECUTIVE VICE PRESIDENT, BROWARD COUNTY MEDICAL ASSOCIATION, FORT LAUDERDALE, FL

Congressman Mica, Members of the House Committee, Distinguished Guests, Ladies and Gentlemen:

To dispel the premise that Doctors do not care for Health Maintenance Organization let me state that of those who have a specialty 85% of them and those who are in general medicine or doing general practice, 30% have contracts with an alternative method of delivering which they will take fees under that contrect arrangement for less than they charge their own private patients so that there is already a marked degree of physicians participation with Health Maintenance Organization under whatever name. The problem between physicians and HMO's and the government and physicians is an economic one pure simple economics. Doctors in private practice have and will continue to have a marked concern as to the quality of medical practice in the community in which they practice. This quality concern has been eroded by people who are offering similar service at less cost. We all know there is no such thing as free medical care. However, it is advertised freely in this community, free eyeglasses, free shoes, free dental, free pharamceutical. We know that's not true. The problem is deceptive advertising. There's where we are concerned and what we're looking for and from governmental pressures is to maintain a quality of practice while assisting people and reducing the cost of care. We do not increase or decrease the cost of care by providing greater access into the system that simply puts more people into it at the same cost and obviously the quality suffers. This is our concern. The problems are those that are still in existence after five years of governmental subsidies of Health Maintenance Organization by whatever name and since we are certain that these will be brought out by other people who are making presentations these are some recommendations.

We would like first to get an audit from Health Care Financing that the general accounting and acoust committee on aging has been asking for for at least two years of my recognition. The first audit being totally unacceptable which stated nothing. I would mention there's probably comparable to the recent release of Health Care Financing administration which compared morbidity rates in several hospitals throughtout the world, throughout the country. Government subsidy competes with private practice and we are not certain nor have we ever been shown that that competition provides in better care for patients provides for less costly care because at the basis it provides 95% of a dollar or 95¢ on every dollar contemplated to be spent for Medicare patients. So it is less costly but is it cost effective that's our problem with it. We have problems with people who would like to go back to Medicare who are dissatisfied with this service who are like people who would like to go HMO's who are on Medicare that is no problem. What we are concerned with is still again and last week I was called by a lady whose mother is 83 years old and is intellectually unsound and who is illerate was called by a recruiter asking would she please come in for her initial physical. The daughter who is in care of this lady has said that she is indeed illerate, she cannot sign her name and she can't see, she's also blind. Now how in the world she ever got into a Health Maintenance Organization is beyond us. We would like to see a health care financing statement, an audit that would say that yes indeed this is cost effective where if it is not lets stop further governmental subsidies for further HMO. Subsidization Florida law requires an internal audit by the Insurance Commissioner, now that is like throwing a rooster in with the chickens. What we are concerned with and what we would like to see is an external audit if we ever get one from the GAL and if we cannot get one from GAL we would like to see the state who authorizes and provides licensure for these organizations to do an internal audit and secondly, we would like to expand that internal audit to the quality of medical practice provided to the people who are saying yes to hospital admissions and no to hospital admissions to see if they are indeed medically qualified to make these recommendations. We have suspicion this may be done by nurses who are looking in books and then thirdly, for patient complaints we would like to see those HMO's receiving governmental subsidies to provide an ombudsman whose position job it is to do nothing but investigate complaints of services, the quality of service provided through HMO's which are governmentally subsidized with medicare and medicaid patients. Thus thirdly and again let us stop this proliferation until we can have something that shows us they are indeed cost effective.

Mr. **Mica**. Let me first ask my colleague if he has any questions.

Mr. **Boucher**. Just a couple, Mr. Chairman.

Mr. Rogers, I noted with interest some of your complaints about the ways that HMO's operate, and I wonder if your complaints are directed across the board at all of the HMO's operating in this area, or if they apply to just one or to several?

Mr. **Rogers**. I would say by and large just one, sir.

Mr. **Boucher**. And that would be IMC, I assume?

Mr. **Rogers**. Yes, sir.

Mr. **Boucher**. Let me ask you to elaborate just a little bit, if you will, on your statement that there is pressure to discharge patients; can you tell me what form that takes and to whom it is communicated—does it come to the hospital or to the treating physician?

Mr. **Roger**. A representative of our medical staff is here today; it is something that I feel he could better address—if you will allow him to speak.

Mr. **Boucher**. I would be happy to hear from him.

Mr. **Rogers**. This is Dr. Neil Schultz.

Mr. **Boucher**. Would you spell your name for the record, please sir.

Dr. **Schultz**. S-c-h-u-l-t-z; first name, Neil, N-e-i-l.

Mr. **Boucher**. We would be happy to hear from you.

STATEMENT OF DR. NEIL SCHULTZ

Dr **Schultz**. The HMO that I have had problems in dealing with has been predominantly IMC. The problem is that when I am called in to see the patient, because I am on call in the emergency room—or if I am called in consultation to see the patient—you go in and the service is provided, the patient is taken care of. When it comes to getting reimbursed for my services, that is where the big problems come up.

We get in touch with the IMC centers in this area, in Broward County, because care is contracted out with different subcontractors that are responsible for payment for the patient's bills. You bill the individual offices, they deny that the patient is their patient, they do not pay the bill; you send the bill into IMC's main office in Miami and you get the same problem, nothing happens.

I have had bills outstanding since I have been in practice up here, for the past year and a half, since February of last year, that have not gotten paid. IMC has been called a multiple of times; I sent letters to IMC, I have sent letters to the State Insurance Commissioner, I have sent letters to the individual clinic where the patients belong, with nothing—there is no response, nothing happens, you do not hear anything.

Mr. **Boucher**. Well, let me ask this: I understand your answer to be more along the lines of problems that you are having in collecting money. I am concerned primarily—at the moment at least—about the practice that HMO's—in particular, IMC—are alleged to be engaging in that involves pressure to discharge on an early basis. Does that pressure come to you directly, or is it——

Dr. **Schultz**. Yes, it does.

Mr. **Boucher** [continuing]. Made to the hospital staff? Tell me the form in which it comes.

Dr. SCHULTZ. You usually get phone calls from either a secretary in one of the HMO clinics, or possibly a physician who works for that clinic, putting strong pressure on you that the patient has to be discharged. Not really paying much attention as to how critically ill the patient is or anything like that, they just start putting pressure on you saying that the patient has to—either "You have to send the patient out, you are keeping him in there too long."

Mr. BOUCHER. Do they have categories of time, akin to DRG's, stating the appropriate length of time for hospital admission for particular illnesses?

Dr. SCHULTZ. Not that I am aware of. Usually it is when you get a patient that is a member of the HMO and you just routinely would get phone calls every other day from the HMO stating that the patient's been in the hospital too long and you have to get the patient out as soon as possible.

And if you tell them that the patient's condition really does not warrant discharge at this time, they say, "Well, the patient has really been there too long, and you are just keeping him in the hospital for an excessive period of time."

Mr. BOUCHER. How do you respond to that, what is your——

Dr. SCHULTZ. The response is saying that the patient will be discharged at a time when the patient is ready to leave the hospital—when they are medically stable.

Mr. BOUCHER. So, in other words, you do not bow to that kind of pressure?

Dr. SCHULTZ. I do not bow to that kind of pressure, but it is harassment. I mean, it is tough enough today practicing medicine with threats of malpractice and, threats of inflation and threats of everything else, to have to undergo harassment from some secretary in an HMO telling you that your patient is in the hospital, you are concerned about him, you are worried about him just having the patient coming out and leading a normal life afterwards, you have to get harassed on top of that by some secretary telling you that the patient has to be discharged.

Mr. BOUCHER. Do you find the HMO's ever getting to the point of saying, "If you do not discharge you patient within 'X' period of days, we are not going to reimburse you for the services you are providing"?

Dr. SCHULTZ. No they never make that threat. They never pay either, so——

Ms. ALEGRE. May I add on that point. It is true for our office as well, when we have had a patient admitted under an emergency situation and this patient for a fact is having angina at bedrest or he is on a IV nitroglycerin drip, the doctor is being requested to justify why this patient is not stable enough to be transferred to an HMO facility to have this open heart surgery or to have this procedure that is medically necessary.

So hours are spent trying to justify this procedure and then once it is justified, once you can find someone there that admits, "Fine, go ahead and treat this patient," or, "Let's get this patient out of here," everyone in the hospital system is willing to move along, which is what they want to do in the beginning.

You then have an authorized situation which never gets paid. We have been told by IMC, "If you just go by our rules, and these are our rules: You must get an authorization for these procedures, and if you present us an authorization, fine, it will be paid." Well, I have authorizations sitting in the office that are 9, 10, 14 months old.

And as to the question that was put to the committee as to the way a claim is filed, I am well aware of how claims are filed, and I believe most private physicians—and that is what we are talking about here—outside the HMO care facility petitions HMO for payment.

They do so with the same file that is petitioned to Medicare. It is an AMA form, we answer the same questions, we provide the authorization number, their membership number, and the same questions that are required for Medicare.

And if it is required for Medicare and acceptable for Medicare and every other private insurance company in the United States, it certainly should be acceptable to IMC.

I propose that this is just another stalling technique of nonpayment.

Mr. BOUCHER. Thank you.

Mr. Rogers, let me ask one additional question.

You had mentioned that under some circumstances it would be possible that the patient would have no coverage at all, either from the HMO or from Medicare, and I question that.

It would seem to me that if the person has disenrolled from the HMO, then the person automatically becomes eligible for Medicare one again; am I wrong in making that assumption?

Mr. ROGERS. You are not totally.

Mr. STAFFORD. No, you are not correct. It is the timeframe that you are confused with.

Mr. ROGERS. I believe it is a 30-day window right now that patients get caught between at a point of disenrollment between one and the other. I have known problems up front when you are calling in 12 specialists to help this very seriously ill patient and you cannot verify insurance one way or the other.

These patients get very upset, and again the emotional trauma is one thing you also have to take into consideration when you are looking at the equality of care from an HMO standpoint.

Mr. BOUCHER. The problem is a practical one, nor a legal one, really.

Mr. ROGERS. Right.

Mr. BOUCHER. The person is eligible for Medicare the very moment that he no longer is enrolled with the HMO. The difficulty is having the fact of that disenrollment recorded on the HHS data base so that you, the health care provider, can contact HHS and find out whether or not that person is eligible for Medicare or not.

Mr. ROGERS. Right.

Mr. STAFFORD. And you must realize, Mr. Boucher, that neither jumps into the fire, they all back away from it.

Ms. ALEGRE. We have justified cases of where the patient—there's no payment been made, and we have appealed to Medicare and we have documentation of Medicare's denial and we have documentation of the HMO's denial.

Mr. MICA. Each claiming the other owed——

Mr. ALEGRE. Absolutely, and this has gone on for 14, 15 months; I am not talking about a 30-day period here.

And, again, may I submit that our concerns are not so much only for payment, as an office manager that is what we are presenting to you, but as an office manager, we also see the patient is unaware of the possibilities that they are going to confront an emergency situation where their HMO is totally ineffective and they, indeed, are stuck with the bill.

Dr. ROGERS. The patients also have problems when they join the HMO and give up their private coinsurance and then at which point they decide to disenroll from the HMO, and they try to get insurance from Blue Cross/Blue Shield, or whichever other organization they have been insured. At that point, some people are told they are no longer eligible, or whatever preexisting illnesses that they have are going to be excluded.

Mr. BOUCHER. Thank you very much. That is all I have.

Mr. MICA. Doctor, you mentioned you had not been paid. Have you been notified that it is a problem with paperwork?

Dr. SHULTZ. No. I have received no notification from IMC at all.

Mr. MICA. Do you have documentation of all the cases that you have not been paid on, any notification that the majority of those cases, or a large percentage, or a percentage, need more documentation for them to pay?

Ms. ALEGRE. Documentation in that they have lost the claim. There is no record of your claim. If we hear that anymore, there will not be any space to write it. We have documentation—every time we have a conversation concerning that patient, it goes on their card. I have cards, for patients with no payments, that are six-cards long, and I can name you personnel and name you patients and all of the excuses for why they are not paid.

Mr. MICA. Let me ask you this: Can either of you tell me, just from searching your memory, does most of this apply to a period of last October, November, December, or is a good deal of this well before that and after that?

You have heard testimony that apparently they had a computer breakdown in October. I noticed with some interest that someone who testified—I think with some interest that someone who testified—I think it was Mr. Dworkin—indicated that his problem was around October. I do not know. I am searching for some ray of hope here.

Dr. SCHULTZ. My personal feeling is it is an ongoing problem. I really have not seen any difference between, you know, getting paid——

Mr. MICA. Before October, after October.

Dr. SCHULTZ [continuing]. Not getting paid before October, getting paid—not getting paid after October. The general consensus is that you do not get paid.

Mr. MICA. Well, now, one other question, and I do not know that this is the right panel, but our constituents are getting dunning notices from collectors. Is there some procedure, would it be more appropriate if you had some other way to collect this or someone to enforce it than to go to the patient—when they are not responsible in any case, it is either going to be Medicare or it is either going to be the HMO. Who pays the bill, correct?

Ms. Alegre. Well, when you indicate that they are not responsible—we have no choice but to bill——

Mr. Mica. Oh, I understand that.

Mr. Alegre [continuing]. Bill the situation. What we do is—the dunning notice is the last thing. I mean, we have left some as long as a year before any threats of collection have occurred, and only after we send documentation to the patient verifying all the information that we have sent to the HMO, so the patient is well aware of the fact that we have billed the HMO and all correspondence we have had with the HMO.

Now, if we have nowhere else to go; we have gone to the Insurance Commission, we have gone to IMC Patient Relations——

Mr. Mica. Well, now, let me just ask you this and, again, I may have the wrong panel here. Under what legal circumstance would a patient have to pay the bill if they are a member of an HMO and the HMO has authorized that care? That care would ultimately have to be paid for by an HMO, is that correct?

Mr. Alegre. As we have stated here, when it is not authorized, HMO's policy is that if it is a dire emergency, of course, that payment will be made, because if you can substantiate the emergency situation then certainly that patient is going to get the necessary care.

In those situations, what legal recourse do you have? We must bill the institute that we provide the service to—we did not provide it to the HMO, we provided it to the patient, so we must turn to the patient.

We do not turn to the patient, we bill their insurance company or their HMO and go through this lengthy process.

Mr. Mica. Well, did I leave out something then? Are a lot of the claims that are not being paid claims that are not authorized?

Mr. Alegre. No, they are both.

Mr. Mica. What percentage?

Ms. Alegre. For our office, I would estimate that 80 percent of our claims are authorized, the other 20 percent are strict emergencies that have no time to authorize. We speak as noncontract HMO physicians, we do not seek out HMO patients, we treat them only when we are called to treat them through emergency room call duty.

So, the physician has no choice in treating or not treating that HMO patient.

Mr. Mica. Mr. Rogers, with regard to the hospital sending—at what point do you turn them over the collectors?

Mr. Rogers. Sir, I have not really had major complaints about the hospital payment by HMO's. I really cannot say from Northwest Regional Hospital's standpoint, that there has been a major problem. However, IMC currently owes us $408,000 which has been due for over 30 days.

Mr. Mica. Were these paid on time?

Mr. Rogers. Not on time, but within 30 days would be reasonable.

Mr. Mica. Within reason.

Mr. Rogers. What does concern us, though, is when I am up until 3 in the morning and we have a physician that is on call saying, "I do not want to take another HMO patient, they owe me $40,000 as it is."

That is the hospital's concern. Dr. Sayfie is in the back, maybe he can answer that for you, sir.

Mr. Mica. Doctor, would you, if you would, come and identify yourself—and I must tell you, we are going to have to clear this room in about 3 minutes. We will submit additional questions in writing.

If you would identify yourself and answer this last question.

Dr. Sayfie. My name is Earnest Sayfie and I am a physician in Hollywood, FL, past chief of staff at Memorial Hospital. And the problems that we had included payment problems, which after discussion with IMC, we had an agreement that when we would submit the bills personally to them that there would be a 30-day period at which time the bills would be paid, and we have had no problem personally at Memorial Hospital.

Mr. Mica. All right. We have—I have a large number of questions that I would like to continue to ask, but the city is waiting to close down the room, and I appreciate each of you being with us.

I must say again in conclusion that our intent here is not to criticize HMO's, not to praise or condemn, but to find out what problems exist and try to correct them.

I am concerned that there are some problems that need addressing and we are going to try to do this. I think the testimony here today has set the groundwork.

This hearing unfortunately, has raised more questions than answers, and this is not the end, it is the beginning and we will try to resolve this in a way that we hope will contribute to quality health care for the people of this area and this country.

Thank you very much.

The Committee on Aging is adjourned.

[Whereupon, at 5 p.m., the hearing was adjourned.]

[All individual testimony not represented due to printing expense has been forwarded to the appropriate agencies.]

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